

Evidence for change of  
first name is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10083

Reg. No. G 120 MAY 17 1949 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County 24  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Dead on arrival  
Hospital, institution, or street address where death occurred:  
Annapolis Emergency Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Fort Meade  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

David

Daniel Thompson Adams

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 27<sup>th</sup> 1948 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 1 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D.C.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Chaplin Rowland C. Adams

13. Birthplace Indiana

14. Maiden name Dora Thompson

15. Birthplace Indiana

16. Informant Rowland C. Adams

Address Fort Meade AAG Md.

17. Removal Date thereof Oct 12<sup>th</sup> 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Corydon Ind.

18. Funeral director John M. Taylor, Son

Address Annapolis Md.

19. Oct. 11 48  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 19 48 at 3 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination  
and that I feel saw him live on Oct. 10 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Acute Fulminating Septicemia

Due to Pneumonia both lungs a few hours

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Same as stated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John M. Taylor, M.D. Deputy Medical Examiner

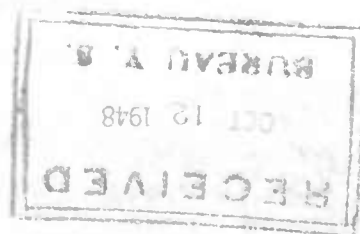
Address Annapolis Md. Date signed 10-11-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10084

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County a. a.  
 City or town Linthicum  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 yrs.  
 Hospital, institution, or street address where death occurred:  
Nursery Rd.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County a. a.  
 City or town Linthicum  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Thompson Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Victor Adams J.

## 3. (b) Social Security Number

216-01-3835

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 19 - 1876  
 8. AGE: Years 72 Months 3 Days 27 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Philadelphia  
 (Town, county, and state)  
 10. Usual occupation Machinist  
 11. Industry or business J. F. W. Dorman  
 12. Name Victor Adams  
 13. Birthplace Paris, France  
 14. Maiden name Elizabeth Wallisser  
 15. Birthplace Switzerland

16. Informant Mrs. Belle Haberkorn  
 Address Nursery Rd., North Linthicum, Md.

17. Burial Date thereof Oct. 19, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Trinity Cem.  
 Location Baltimore, Md.

18. Funeral director WM. J. TICKNER & SONS  
 Address Balto., Md.

19. 10/15 45 SA Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 19 48 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 19 48 to Oct. 16 19 48  
 and that I last saw him alive on Oct. 16 19 48

Immediate cause of death Ruptured Aneurysm of abdominal aorta  
 DURATION 2 days

Due to  
 Due to

Other conditions Arteriosclerosis 10 yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Chas. L. Baez  
 M.D. or other  
 Address Linthicum Date signed 10-16-48

Belle Haverhorn  
HAVERKORN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10144

Reg. Dist. No. 22

## 1. PLACE OF DEATH:

County A.A.City or town Jessups  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:  
Maryland House of CorrectionHow long in hospital or institution? Hospital - 2 mo. 21 da

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.City or town Jessups  
(If outside city or town limits, write RURAL and give nearest town)Street No. Maryland House of Correction  
(If rural, give LOCATION)

2(a) If veteran, name war.....

## 3. (a) FULL NAME

BANKS, Thomas

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorcedWidower6. (b) Name of husband or wife unknown7. Birth date of deceased (mo., day, yr.) Apr. 19, 1896  
6. (c) If alive, give age --- years8. AGE: Years 52 Months 6 Days 2 If less than one day  
--- hrs. --- min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Dock laborer & farm worker

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name Comfort Barbour15. Birthplace Charles City, Va.16. Informant Maryland House of CorrectionAddress Jessups, Md.17. Removal Date thereof 10. 24. 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WashingtonLocation 20 E.18. Funeral director Robert S. McQuinnAddress 1820 - 9 St. N.W. Wash. D.C.19. Oct 21 19 48 Lolasa Washuk  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948 at 4:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 23, 1948 to Oct. 21, 1948and that I last saw him alive on 19Immediate cause of death Exhaustion

DURATION

Due to CarcinosisDue to Carcinoma of prostate

Other conditions -----

(Include pregnancy within 8 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE John A. Clark M.D. M. D. or otherAddress Maryland House of Correction Date signed -----

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10085

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Marley Park (Glen Burnie P.O.)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 yrs.  
 Hospital, institution, or street address where death occurred:  
Old Annapolis Blvd.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Marley Park, Glen Burnie, B.O.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Old Annapolis Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Cora May Blizzard

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow  
 8. (b) Name of husband or wife John B. Blizzard  
 8. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 14, 1884  
 8. AGE: Years 64 Months 5 Days 29 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mt. Vernon, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife (ret.)  
 11. Industry or business Own Home  
 12. Name Charles E. Marsden  
 13. Birthplace Mt. Vernon, Md.  
 14. Maiden name Anna A. Scott  
 15. Birthplace Mt. Vernon, Md.

16. Informant Mrs. Anna Murray  
 Address Marley Park, Glen Burnie, P.O.  
 17. Burial Date thereof Oct. 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Gov. Ritchie Hgwy. Bklyn., Md.  
 18. Funeral director Thomas W. Singleton  
 Address Glen Burnie, Md.

19. 10/16 1948 L. J. O. Allen  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/48 19\_\_\_\_ at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/14/46 19\_\_\_\_ to 10/14/48 19\_\_\_\_  
 and that I last saw h at alive on 10/13/48 19\_\_\_\_  
 Immediate cause of death

Due to Carcinoma  
of the uterus  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE John C. Snyder MD M. D. or other \_\_\_\_\_  
 Address Glen Burnie Date signed 10/16/48

RECEIVED  
OCT 18 1948  
BUREAU 4.5

Dr. Boit.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10086

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Emergency Hospital  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Annapolis, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 Fleet St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

JACOB BLUM

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Fannie Blum

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Nov. 10, 1885

## 8. AGE:

Years

Months

Days

If less than one day

62

hrs.

min.

## 9. Birthplace

Russia

(Town, county, and state)

## 10. Usual occupation

Merchant

## 11. Industry or business

FATHER

## 12. Name

Elago Blum

## 13. Birthplace

Russia

## 14. Maiden name

unknown

## 15. Birthplace

unknown

## 16. Informant

Fannie Blum

## Address

6 Fleet St. Annapolis, Maryland

## 17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof Oct. 15, 1948

(month) (day) (year)

## Cemetery or crematory

Kneseth Israel Cemetery

## Location

3 mile oak, A.A. Co. Maryland

## 18. Funeral director

Ben L. Hopping and Son

## Address

170-172 West St. Annapolis, Md.

## 19.

Oct. 15 1948

(Date rec'd by registrar)

W Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 19 48 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 12 19 48 to Oct 14 19 48  
 and that I last saw him alive on Oct 14 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C Boit  
 M. D. or other  
 Address Annapolis Md Date signed 10-14-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10087

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Crownsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since March 5, 1946Hospital, institution, or street address where death occurred:  
Crownsville State HospitalHow long in hospital or institution? 2 years 7 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2409 Druid Hill Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MINNIE BOGGS

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Gardner Boggs7. Birth date of deceased (mo., day, yr.) 1900? 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 48? Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation housework

## 11. Industry or business \_\_\_\_\_

12. Name Charles Mills13. Birthplace Maryland14. Maiden name Annie Backer15. Birthplace Virginia16. Informant Hospital RecordsAddress Crownsville State Hospital17. Int. Autopsy Date thereof 10/14/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ByrdalLocation Ind.18. Funeral director Mrs. H. KelsayAddress 1303 Presstman19. Oct 14 48 9.20/Heiduck  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 9:00 a m21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1946 to October 11, 1948  
and that I last saw h. or alive on October 11, 1948

## Immediate cause of death

Chronic Myocarditis

## DURATION

3/5/46

## Due to \_\_\_\_\_

## Due to \_\_\_\_\_

Other conditions Lung tuberculosis 3 mos.  
Bone tuberculosis 3 mos.  
(Include pregnancy within 3 months of death)

## Major findings of operations. \_\_\_\_\_

Date of op. \_\_\_\_\_

## Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following: \_\_\_\_\_

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Joseph Mayenst M. D. or otherCrownsville, Maryland Date signed 10/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10088

Reg. Dist. No.

21

## 1. PLACE OF DEATH:

County G.A. Co  
 City or town Annapolis Emergency Hospital  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AA  
 City or town Dumbarton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Daniel Boston

## 3. (b) Social Security Number

2

4. Sex

M.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age \_\_\_\_\_ years

18 6 4

8. AGE:

54

Years

Months

Day

If less than one day

hrs.

min.

9. Birthplace

West River

(Town, county, and state)

10. Usual occupation

look

11. Industry or business

MOTHER FATHER

12. Name

Daniel Boston

13. Birthplace

Unknown

14. Maiden name

Louise Turner

15. Birthplace

West River

16. Informant

Alize Turner

Address

Box 551 Route 3 Annapolis

17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

Cemetery or crematory

Daniel Star

Location

West River Md

18. Funeral director

D. A. Hardy + Son

Address

Salisbury Md

19.

(Date rec'd by registrar)

Oct. 5 19 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 319 48at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/1519 48to Oct 319 48

and that I last saw him alive on

Oct 319 48

Immediate cause of death

arteriosclerosis and cardio-vascular disease

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

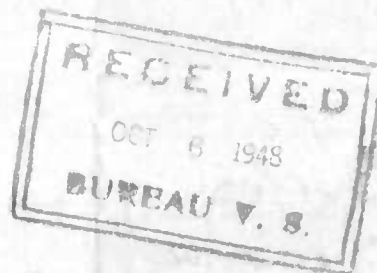
23. SIGNATURE

S. B. BrownM.D.

M. D. or other

Address

Annapolis MdDate signed 10/4/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10089

Reg. Dist. No. 2/

### 1. PLACE OF DEATH:

County Q. A.  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 84 Conduit  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Elizabeth E. Boucher

### 3.(b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6.(c) Single, married, widowed, or divorced

Widow

### 6.(b) Name of husband or wife

Myers J. Boucher

6.(c) If alive, give age years

#### 7. Birth date of deceased (mo., day, yr.)

March 3<sup>rd</sup> 1865

#### 8. AGE:

Years 83

Months 7

Days 5

If less than one day

hrs. min.

#### 9. Birthplace

Annapolis Md.  
(Town, county, and state)

#### 10. Usual occupation

none

#### 11. Industry or business

#### FATHER

##### 12. Name

J. Philip Hopkins

##### 13. Birthplace

Annapolis Md

#### MOTHER

##### 14. Maiden name

Unknown

##### 15. Birthplace

#### 16. Informant

Mrs John F. Murphy

##### Address

84 Conduit St. Annapolis Md.

#### 17.

Burial

Date thereof Oct 13-48

(Burial, cremation, or removal. Which? (month) (day) (year))

##### Cemetery or crematory

St. Annes

##### Location

Annapolis Md.

#### 18. Funeral director

John M. Taylor, Son

##### Address

Annapolis Md.

#### 19.

Oct. 13 19 48

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

October 10<sup>th</sup> 19 48 at 11:50 P

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1947 to Oct-10 19 48

and that I last saw him alive on Oct 10 19 48

#### Immediate cause of death

Acute Cardio Vascular Failure

#### Due to

Acute Cardiac Dilatation

#### Due to

Cr. Myocarditis

#### Other conditions

about 2 yrs.

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

#### 23. SIGNATURE

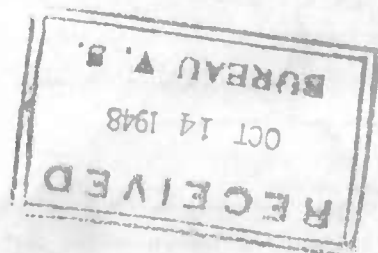
J. Oliver Purvis  
Annapolis Md Date signed 10/12/48

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10090

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Chesapeake Bay  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution or street address where death occurred:

off the Severn Point Knoll

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3052 Mathews St  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Leland B. Bowers

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Margaret Metz Bowers7. Birth date of deceased (mo., day, yr.) 1902

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

46

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

Arundles Sand & Gravel Co.12. Name George Bowers

MOTHER

FATHER

13. Birthplace

(?)

14. Maiden name

Bretwiser

15. Birthplace

(?)18. Informant Mrs. Margaret M. BowersAddress 3052 Mathews Street17. Burial  
(Burial, cremation, or removal. Which?)Date thereof 10/9/48  
(month) (day) (year)Cemetery or crematory Baltimore Cemetery

Location

WIEDEFELD AND SON

18. Funeral director

GREENMOUNT AVE. & 22nd ST.

Address

BALTIMORE - 18, MARYLAND19. 10-8 19 48  
(Date rec'd by registrar)A. W. Kralich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th 19 48 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death

Accidental drowning

DURATION

Sudden

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/5/48Where did injury occur? Chesapeake Bay, A.D. (City or town) md. (State)Injured at home, farm, industry, public place (where?) Chesapeake BayMeans of injury drowning Injured at work? Yes

23. SIGNATURE

Kristal H. Barcher MD  
M. D. or other  
Address Eden, Riverside, Md Date signed 10/4/48

Gen. 18. Fairbank.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10091

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Glen Burnie, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? About 1 year  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Oakwood, Glen Burnie, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Oakwood Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

MARY E. BROWN

### 3.(b) Social Security Number

NONE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Aaron S. Brown

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1875

8. AGE: Years Months Days If less than one day  
73 7 16 hrs. min.

9. Birthplace Wiirtherberg, Germany  
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Conrad Wengert

13. Birthplace Germany

14. Maiden name Rosie Walker

15. Birthplace Germany

16. Informant Miss Sylvia H. Brown

Address Oakwood, Glen Burnie, Md.

17. Burial Date thereof Nov. 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas V. Singleton

Address Glen Burnie, Md.

19. Oct 31 19 48 L. J. De Schenck  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 19 48 at 10:48 PM

21. CERTIFY that death occurred on the date above stated; that patient died from Sept 15 19 48 to Oct 27 19 48  
and that last saw him alive on Oct 27 19 48  
Immediate cause of death Pericarditis

Anaemia

DURATION

Other conditions Arteriosclerosis  
Myocarditis  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

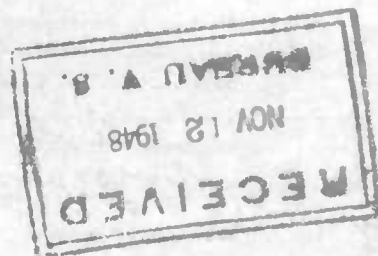
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE John G. Schenck, M.D.  
1337 S Charles St. M. D. or other  
Address Date signed 10/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10092

Reg. Dist. No. 26

<b>1. PLACE OF DEATH:</b> County <u>Ches. Annel</u> City or town <u>Crownville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>17 days</u> Hospital, institution, or street address where death occurred: <u>Crownville State Hospital</u> How long in hospital or institution? <u>17 days</u>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____		
<b>3. (a) FULL NAME</b> <u>Richard Brown</u>			<b>3. (b) Social Security Number</b>		
<b>4. Sex</b> <u>Male</u> <b>5. Color or race</b> <u>colored</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>Single</u>			<b>MEDICAL CERTIFICATION</b>		
<b>6. (b) Name of husband or wife</b> _____ <b>6. (c) If alive, give age</b> _____ years			<b>20. DATE OF DEATH</b> <u>October 9<sup>th</sup></u> 19 <u>48</u> at <u>12 noon</u>		
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>abt. 1903</u>			<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>September 22<sup>nd</sup></u> 19 <u>48</u> <b>to</b> <u>October 9<sup>th</sup></u> 19 <u>48</u> <b>and that I last saw him alive on</b> <u>October 9<sup>th</sup></u> 19 <u>48</u>		
<b>8. AGE:</b> Years <u>45<sup>2</sup></u> Months _____ Days _____ If less than one day _____ hrs. _____ min.			<b>Immediate cause of death</b> <u>Cerebral hemorrhage</u> <b>DURATION</b> <u>3 days</u>		
<b>9. Birthplace</b> <u>Unknown</u> (Town, county, and state)			<b>Due to</b> <u>Hypertensive heart disease</u> <u>known to us since Sept. 22 - 48</u>		
<b>10. Usual occupation</b> <u>Unknown</u>			<b>Due to</b> _____		
<b>11. Industry or business</b> _____			<b>Other conditions</b> <u>Psychosis with cardiac vascular disease</u> <u>known to us since Sept. 22 - 48</u> (Include pregnancy within 3 months of death)		
<b>12. Name</b> <u>Unknown</u>			<b>Major findings of operation</b> _____		
<b>13. Birthplace</b> <u>Unknown</u>			<b>Date of op.</b> _____		
<b>14. Maiden name</b> <u>Unknown</u>			<b>Autopsy results</b> _____		
<b>15. Birthplace</b> <u>Unknown</u>			<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>		
<b>16. Informant</b> <u>Hospital Records</u> <b>Address</b> <u>Crownville Md.</u>			<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>		
<b>17. Burial</b> <u>Brooklyn, Md.</u> <b>Date thereof</b> <u>Oct. 13-48</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <b>Cemetery or crematory</b> <u>Brooklyn, Md.</u> <b>Location</b> <u>Chas. O. Wilson</u>			<b>Accident, suicide, or homicide</b> _____ <b>Date of</b> _____		
<b>18. Funeral director</b> <u>1000 Brantley Ave</u> <b>Address</b> <u>Oct 13 1948 A.W. Hedrick</u>			<b>Where did injury occur?</b> _____ (City or town) _____ (County) _____ (State)		
<b>19. Oct 13 1948 A.W. Hedrick</b> (Date rec'd by registrar) Registrar			<b>Injured at home, farm, industry, public place (where?)</b> _____		
			<b>Means of injury</b> _____ <b>Injured at work?</b> _____		
			<b>23. SIGNATURE</b> <u>James M. Hedrick M.D.</u> <b>M. D. or other</b> _____		
			<b>Address</b> _____ <b>Date signed</b> _____		

1945  
46  
1903

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10093

Reg. Dist. No. 20

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Mayo  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 68 yrs  
Hospital, institution, or street address where death occurred:  
Mayo, Md. nr Daves Corner  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
City or town Mayo  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. nr Daves Corner  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

WILLIAM HENRY BURGESS

### 3.(b) Social Security Number

218-05-7076

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs Elsie Lee Burgess

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 28, 1880

8. AGE: Years 68 Months 6 Days 10 If less than one day hrs. min.

9. Birthplace Mayo, A.A. Co. Maryland  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Theodore Burgess

13. Birthplace unknown

14. Maiden name Mary Rogers

15. Birthplace Maryland

18. Informant Mrs Elsie Lee Burgess

Address Mayo P.O. Mayo, Maryland

17. Burial Date thereof Oct. 10, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All Hallows

Location Birdsville, A.A. Co., Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

19. Oct. 9, 1948 Edward Collens

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 48 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46 to Oct 8 19 48

and that I last saw him alive on Oct 5 19 48

Immediate cause of death

progressive arteriosclerosis of cerebral blood vessels

Due to senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil H. Wilson M.D.

M. D. or other

Address Cuthrie Md.

Date signed 10/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

172

21  
10055

1. PLACE OF DEATH: Found: Chesapeake Bay in  
(a) ~~Baltimore City, Maryland~~ vicinity of 7' Knoll  
(b) ~~Street address.~~  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

CARLOS

TIRADO

CARILLO

3 (b) If veteran, name war

3 (c) Social Security Account

No. 215-28-5626

4. Sex  
Male5. Color or race  
White6 (a) Single, married, widowed, or  
divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-1929

8. AGE: Years Months Days If less than one day  
18 11 27 hr. min.

9. Birthplace: Fagordo Puerto Rico

(Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Arundel Corporation

12. Name: Angel T. Tirado

13. Birthplace: Puerto Rico

14. Maiden Name: Conrado Carrillo

15. Birthplace: Puerto Rico

16 (a) Informant: Arundel Corporation

(b) Address

17 (a) Burial (b) Date thereof 10/13/48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Baltimore

18 (a) Funeral director: Leonard J. Luck

(b) Address: 5305 Harford Rd.

19 (a) Oct 13 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town: Baltimore  
(If outside city or town limits, write RURAL and give town)(d) Street No.: 831 N. Washington Street  
(If rural give location)(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an  
Insp. & Inquiry thereon and from the evidence obtained  
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came  
to his death on the day stated above, and death in my  
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,  
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH:

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of  
death, fill in the following:

(a) Date of injury: 10-5-48 at 11:15 A. M.

(b) Where did injury occur? Chesapeake Bay, 3/4 mile  
below 7' Knoll(c) Did injury occur at home, on farm, industrial place, in public  
place? Chesapeake Bay While at work? Yes

(d) Means of injury: Tugboat Capsized

23. Signature: George B. Merrill M.D.

Medical Examiner.

Date signed: 10/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## CERTIFICATE OF DEATH 172

Registered No. 10094

1. PLACE OF DEATH: Found: Chesapeake Bay in  
(a) Baltimore City, Maryland vicinity of 7' Knoll  
(b) Street address.....  
(c) Hospital or institution:.....

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County.....

(c) City or town Brooklyn  
(If outside city or town limits, write RURAL and give town)

(d) Street No. 397 Dean Street

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... N.

3 (a) FULL NAME

ARNIE

CARLSON

3 (b) If veteran, name war

3 (c) Social Security Account

No. 134-24-0930

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1925

8. AGE: Years 23 Months 2 Days 28 If less than one day  
.....hr. ....min.

9. Birthplace Sweeden

(Town, county, and state)

10. Usual Occupation Deck Hand

11. Industry or business Seaman

12. Name Carl Gostafsen

13. Birthplace Sweeden

14. Maiden Name Nannie Carlson

15. Birthplace Sweeden

Erickson Funeral Home

16 (a) Informant Brooklyn, N. Y.

(b) Address

17 (a) Removal (b) Date thereof 10/11/48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Fresh Pond

Location Brooklyn, N.Y.

William Cook, Inc.

18 (a) Funeral director

(b) Address 1217 St. Paul Street

19 (a) OCT 11 1948  
(Date rec'd by registrar)

Huntington Williams, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 19 48 at 2:30 PM

21. I certify that I took charge of the remains described above, held an  
Insp. & Inquiry thereon and from the evidence obtained  
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came  
to his death on the day stated above, and death in my  
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,  
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to.....

Other Conditions.....

(Include pregnancy within 8 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of  
death, fill in the following:

(a) Date of injury 10-5-48 at 11:15 A. M.

(b) Where did injury occur? Chesapeake Bay, 3/4 mile

(c) Did injury occur at home, on farm, industrial place, in public  
place? Chesapeake Bay While at work? Yes

(d) Means of injury Tugboat, Capsized

23. Signature George L. Merrill M.D.

Date signed 10/11/48

Medical Examiner.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10095

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 Months  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital, Annapolis, Md.  
How long in hospital or institution? Three (3) days.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Minnesota County \_\_\_\_\_  
City or town Minneapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5644 Longfellow Ave., S. Minneapolis, Minn.  
(If rural, give LOCATION)  
2.(a) If veteran, name war World War II ✓

### 3. (a) FULL NAME

CARLSON, Willard Erick

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife None  
7. Birth date of deceased (mo., day, yr.) 12-6-1927 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 20 Months 9 Days 29 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Minneapolis Minnesota  
(Town, county, and state)  
10. Usual occupation U.S. Navy.  
11. Industry or business U.S. Navy.  
12. Name Erick Walter CARLSON  
13. Birthplace Norway.  
14. Maiden name Eva S. OLSON  
15. Birthplace Minnesota.

16. Informant Willard Erick CARLSON (Obtained from previous admission at this hospital.)  
Address \_\_\_\_\_

17. Removal Date thereof Oct. 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory \_\_\_\_\_  
Location Minneapolis, Minnesota

18. Funeral director Ben L. Hopping and Son  
Address 170-172 West St. Annapolis, Maryland

19. Oct. 6 48  
(Date rec'd by registrar) Registrar [Signature]

### MEDICAL CERTIFICATION

20. DATE OF DEATH 5 October 19 48 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 October 19 48 to 5 October 19 48  
and that I last saw him alive on 5 October 19 48

Immediate cause of death Respiratory Failure. DURATION \_\_\_\_\_

Due to Epidural Hematomata Bilateral & Left Frontal Lobe Contusion.

Due to Skull Fracture.

Other conditions Ventral Hernia, Traumatic with Contusion Caecum.

(Include pregnancy within 3 months of death)

Major findings of operations None.

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Accident Date of 2 Oct. 1948  
Where did injury occur? A Anne Arundel, Md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Riva Road.  
Means of injury Motorcycle Accident Injured at work? No.

23. SIGNATURE E. Peyton Ritchings, M.D.  
E.P. RITCHINGS, Acting County  
Medical Examiner. M. D. or other  
Address Annapolis, Maryland. Date signed Oct. 6, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10097

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County A. A. County  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 419 Third Avenue S. W.  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

WILLIAM W. COX

### 3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Anna Mary</u>			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>August 12, 1874</u>			
8. AGE: Year <u>74</u>	Month <u>1</u>	Day <u>21</u>	If less than one day _____ hr. _____ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation Cloak Presser  
11. Industry or business Retired  
12. Name Charles E. Cox  
13. Birthplace Vicksburg, Miss.  
14. Maiden name Mary Clara Reeder  
15. Birthplace Maryland

18. Informant Mrs. Anna Mary Cox  
Address 419 Third Avenue S. W.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Oct. 7, 1948  
(month) (day) (year)  
Cemetery or crematory Glen Haven  
Location A. A. County, Maryland  
18. Funeral director William Cook, Inc.  
Address 1217 St. Paul Street

19. 10/5 1948 R. W. Helmer  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1948 at 12:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Oct. 3, 1948  
and that I last saw him alive on Oct. 2, 1948

Immediate cause of death Chronic Disease of the Heart  
Due to Coronary Vascular Disease  
Due to \_\_\_\_\_  
Other conditions Cancer of the Liver

DURATION  
2 years

2 years

5 years

(Include pregnancy within 3 months of death)  
Major findings of operations Cancer of the Liver  
Date of op. 1944

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. S. Beilinger, M.D.  
Address Glen Burnie, Md. Date signed Oct 4, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Basil

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10098  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County..... Anne Arundel  
 City or town..... Cedar Park nr Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 yr  
 Hospital, institution, or street address where death occurred:  
311 Taylor St.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Anne Arundel  
 City or town..... Cedar Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 311 Taylor St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

FRANKLIN ELLSWORTH CRANFORD SR.

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... Annie E. Cranford  
 7. Birth date of deceased (mo., day, yr.)..... July 25, 1876 6.(c) If alive, give age..... years  
 8. AGE: Years..... 72 Months..... 2 Days..... 8 If less than one day..... hrs. .... min.

9. Birthplace..... Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Carpenter  
 11. Industry or business.....  
 12. Name..... James B. Cranford  
 13. Birthplace..... Maryland  
 14. Maiden name..... Unknown  
 15. Birthplace..... Unknown

16. Informant..... Mrs. Lawrence White  
 Address..... 311 Taylor St. Cedar Park, Annap  
 17. Burial Date thereof..... Oct 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Cedar Bluff  
 Location..... Annapolis, Maryland

18. Funeral director..... Ben L. Hopping and Son  
 Address..... 170-172 West St. Annapolis, Maryland

19. Oct 6 48  
 (Date rec'd by registrar) Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 3, 1948 at 9:30p.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1940 to Oct 3 1948  
 and that I last saw him alive on Oct 2 1948

Immediate cause of death..... Cerebral hemorrhage with st. hemiplegia  
 Due to..... Arteriosclerosis  
 Due to..... 8 yrs

Other conditions..... Hypertension  
 (Include pregnancy within 3 months of death)  
 Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

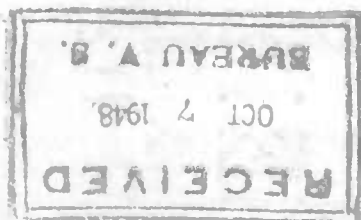
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... George Basil M. D. or other  
 Address..... Annapolis Date signed..... 10. 5. 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10099

### 1. PLACE OF DEATH:

County *Anne Arundel Co.*

City or town *Rural*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD* County *AA*

City or town *Rural, Crumville*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2(a) If veteran, name war .....

### 3. (a) FULL NAME

*Henrietta Edgell*

### 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Capt. John Henry*

7. Birth date of deceased (mo., day, yr.) *May 18 - 1852*

8. AGE: Years *96* Months *86* Days *6* If less than one day *12* hrs. .... min.

9. Birthplace *Carlisle Md.*  
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Charles Heather*

13. Birthplace *Talbot Co Md.*

14. Maiden name *Catherine Keat*

15. Birthplace *Talbot Co Md.*

16. Informant *Maud Edgell*

Address *Crumville Md.*

17. *Burial* Date thereof *6/2/48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Spring Hill*

Location *Easton Md.*

18. Funeral director *William Cook Inc.*

Address *1217 St. Paul St.*

19. *11/1* 19 *48* *A.W. Hedrick*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 30* 19 *48* *3-2*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 *46* 10 *10-20* 19 *47*

and that I last saw h. *or* alive on *Oct - 27* 19 *47*

Immediate cause of death *Sanility*

DURATION

Due to *Age*

Due to

Other conditions *Deaf, Blind* *4 yr*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Ostmac Nemar*

Address *Millsboro Md* M. D. or other

Date signed *10-30-48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10101

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County Anne Arundel  
City or town North Linthicum  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 Years  
Hospital, institution, or street address where death occurred:  
Nursery Road, North Linthicum  
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town North Linthicum  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Nursery Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war None

### 3. (a) FULL NAME

John C. Etzel Sr.

### 3. (b) Social Security Number

215-09-9194

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Anna L. Berger  
6. (c) If alive, give age 70 Years  
7. Birth date of deceased (mo., day, yr.) October 26th., 1876  
8. AGE: Years 71 Months II Days 25 If less than one day ### min.

9. Birthplace Baltimore City, Maryland  
(Town, county, and state)  
10. Usual occupation Retired, Receiving Clerk  
11. Industry or business Gas & Electric Company  
12. Name Joseph Etzel  
13. Birthplace Germany  
14. Maiden name Minnie Dietz  
15. Birthplace Germany

16. Informant Mrs. Anne L. Etzel ---- Wife --  
Address Nursery Rd. North Linthicum, A.A. Co. Md.

17. Burial Burial Date thereof 10-23-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Lorraine Park, Baltimore, Md.  
Location Baltimore County, Maryland  
George J. Ruth, Inc.

18. Funeral director I 735 Harford Avenue, Balto: Md.  
Address

19. Oct 23rd, 1948 R.W.L. A.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION 48

20. DATE OF DEATH Nov. 21, 1948 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 19 48 to Oct. 21 19 48  
and that I last saw him alive on Oct. 21 19 48

Immediate cause of death Coronary Arteriosclerosis DURATION 4 yrs.  
Arterio-sclerosis 5 yrs.  
Due to Arterio-sclerosis  
Due to Arterio-sclerosis  
Other conditions Arterio-sclerosis 18 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations Arterio-sclerosis  
Date of op. Arterio-sclerosis  
Autopsy results Arterio-sclerosis  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Arterio-sclerosis Date of Arterio-sclerosis  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Arterio-sclerosis  
Means of injury Arterio-sclerosis Injured at work?

23. SIGNATURE Chas. L. Ball Jr. MD M. D. or other  
Address Linthicum Date signed 10-21-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 10102

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
(b) Street address: Just below Craig Hill Channel  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Washington  
(c) City or town Waterford  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. R.F.D. #1 (If rural give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

ALLEN B. FARUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1926

8. AGE: Years

22

Months

Days

If less than one day

hr.

min.

9. Birthplace Waterford, Wash. Co. Ohio

(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER

12. Name David Farus13. Birthplace Ohio

MOTHER

14. Maiden Name Alice Chapman15. Birthplace Ohio16 (a) Informant Harry McCurdy(b) Address Beverly, Ohio17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 11/25/48

(month) (day) (year)

(c) Cemetery or crematory

Location Waterford, Wash. Co. Ohio18 (a) Funeral director H.W. MEARS & SON(b) Address 805 N. Calvert St.19 (a) 10/22/48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury Oct. 19/48 6:30 P.M.(b) Where did injury occur? 7th Ft. Knoll  
Ing Columbia(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? Yes(d) Means of injury Drowning23. Signature Earl R. Jones M.D.Date signed 10/22/48

Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10100

21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Riva  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

## 3. (a) FULL NAME

Rudolph R. Fekeith

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widower

## 6.(b) Name of husband or wife

Hortense Fekeith

## 7. Birth date of deceased (mo., day, yr.)

Sept 21<sup>st</sup> 1880

## 8. AGE:

Years 68 Months 0 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Austria  
(Town, county, and state)

## 10. Usual occupation

Electrician Ret.

## 11. Industry or business

Louis Fekeith12. Name Austria13. Birthplace Austria14. Maiden name Unknown

## 15. Birthplace

16. Informant Mrs Evelyn WickstromAddress Riva Md Co. Md17. Removal Date thereof Oct 16<sup>th</sup> 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location New York City18. Funeral director John M. Saylor, SonAddress Annapolis Md19. Oct 16 19 48 John J. French  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 19 48 at 8<sup>10</sup> A M21. I CERTIFY that death occurred on the date above stated Postmortem Examination  
Oct. 15, 19 48

## Immediate cause of death

.22cal BulletDue to Wound in headDue to entering at rightOther conditions Temple

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-15-48Where did injury occur? Riva A. A. Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at daughter's homeMeans of injury .22cal. rifle Injured at work? no23. SIGNATURE John M. Caffy M.D. Deputy Medical Examiner  
Address Annapolis, Md M. D. or other \_\_\_\_\_Date signed 10-15-48

RECEIVED  
OCT 19 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10103

Reg. Dist. No.

23

### 1. PLACE OF DEATH:

County Hann ARUNDEL  
City or town LAUREL RURAL  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 months  
Hospital, institution, or street address where death occurred:  
District Training School  
How long in hospital or institution? 10 mo

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State \_\_\_\_\_ County \_\_\_\_\_  
City or town D.C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Catherine Fisher

### 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S  
6.(b) Name of husband or wife \_\_\_\_\_  
7. Birth date of deceased (mo., day, yr.) Feb. 12 - 1945  
6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 3 Months 8 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington D.C.  
(Town, county, and state)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Catherine Fisher  
13. Birthplace Indiana  
14. Maiden name Kenneth Munsow  
15. Birthplace Toledo, Ohio

16. Informant History of Dist. TR. School  
Address LAUREL, MD  
17. Burial Date thereof Oct 19 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Dist. TR. School  
Location Wash. Laurel Md.  
18. Funeral director Raymond Jones  
Address Laurel Md  
19. Oct 19 48 Glenn Harshup  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1948 at 11 45 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12 1947, to 10-13 1948  
and that I last saw her alive on 10-13 1948  
Immediate cause of death Congenital Debility DURATION Birth  
Due to \_\_\_\_\_  
Due to CO  
Other conditions Mental Deficiency 1st. Birth  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE R. W. Huff MD  
Address Laurel Md M. D. or other MD  
Date signed 10/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU V. S.

Change of year of birth: Evidence is shown on Film G117 10/28/48 js  
 Birth Certificate on file here

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10104

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County *Anne Arundel*

City or town *Annapolis*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *died on arrival*

Hospital, institution, or street address where death occurred:  
*Annapolis Emergency Hospital*

How long in hospital or institution? *died on arrival*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*

City or town *Lothian*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

*James Alvin Ford*

3. (b) Social Security Number

4. Sex

*male*

5. Color or race

*white*

6. (a) Single, married, widowed, or divorced

*married*

6. (b) Name of husband or wife

*Netta Ford*

7. Birth date of deceased (mo., day, yr.)

*May 5, 1900--1901*

8. AGE:

Years *47* Months *14* Days *16* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

*Nutwell, H. A. Maryland*  
 (Town, county, and state)

10. Usual occupation

*Garage*

11. Industry or business

*Automobiles*

FATHER

12. Name

*Harry Ford*

13. Birthplace

*Nutwell, Md.*

MOTHER

14. Maiden name

*Rachael Phipps*

15. Birthplace

*Nutwell, Md.*

16. Informant

*Mrs. J. Alvin Ford*

Address

*Lothian, Md.*

17.

*Burial*  
 (Burial, cremation, or removal, which?)

Date thereof *Oct 23-1948*  
 (month) (day) (year)

Cemetery or crematory

*St James*

Location

*Tracy Landis & Co. Inc.*

18. Funeral director

*John M. Taylor, Son*

Address

*Annapolis, Maryland*

19.

*Oct. 22 1948*  
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 21, 1948* at *1:00* P. M.

21. I CERTIFY that death occurred on the date above stated: *Postmortem Examination*

*Oct. 21, 1948*

Immediate cause of death

*Acute Dilatation of Heart Sudden*

Due to

*Diabetes Mellitus unknown*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

*John M. Caffy M.D. Examiner*

Address *Annapolis, Md.* Date signed *10-20-48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 25 1948

BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 10105

1. PLACE OF DEATH: Found: Chesapeake Bay in the vicinity of 7' Knoll

(a) Baltimore City, Maryland  
(b) Street address  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3700 Hanover Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3 (a) FULL NAME

HOWARD

LEON

FOX

3 (b) If veteran, name war

World War #2

3 (c) Social Security Account

No.

4. Sex  
Male

5. Color or race  
White

6 (a) Single, married, widowed, or divorced.  
Married

6 (b) Name of husband or wife Dessie V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-1912

8. AGE: Years Months Days If less than one day

36

3

13

hr.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Deck Hand

11. Industry or business Arundel Corporation

12. Name Leon Fox

13. Birthplace Maryland

14. Maiden Name Henrietta Schramm

15. Birthplace Maryland

16 (a) Informant Family

(b) Address Same (3700 Hanover St.)

17 (a) Burial (b) Date thereof 10-12-48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Glen Burnie, Maryland

18 (a) Funeral director J. L. McCULLY

(b) Address 130 E. Fort Avenue

(a) OCT 12 1948  
(Date rec'd by registrar)

(b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 2:30 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-5-48, 11:15 A. M.

(b) Where did injury occur? Chesapeake Bay, 3/4 mile

(c) Did injury occur at home, on farm, industrial place, in public place? Below 7' Knoll  
Chesapeake Bay While at work? Yes

(d) Means of injury Tugboat Capsized

23. Signature E. L. Fox M.D.

Date signed 10-11-48 Medical Examiner.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10106

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Died on admission.  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital  
How long in hospital or institution? Died on admission.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Anne Arundel  
City or town Annapolis.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 14 Thompson Street.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW I

### 3. (a) FULL NAME

GANNON, Sinclair (n), RADM, RET, USN

### 3. (b) Social Security Number

4. Sex Male. 5. Color or race White. 6. (a) Single, married, widowed, or divorced Married.  
6. (b) Name of husband or wife Mrs. Dell GANNON  
6. (c) If alive, give age 67 years  
7. Birth date of deceased (mo., day, yr.) March 19, 1877  
8. AGE: Years 71 Months 10 Days 21 hrs. 15 min.

9. Birthplace Texas.  
(Town, county, and state)  
10. Usual occupation U.S. Navy.  
11. Industry or business Rear Admiral Ret.  
12. Name William A. Gannon.  
13. Birthplace New York.  
14. Maiden name Nancy Robinson.  
15. Birthplace Mississippi.

16. Informant Obtained from previous admission.  
Address U.S. Naval Hospital Annapolis  
Private  
17. Date thereof 10-22-48  
(month) (day) (year)  
Cemetery or crematory U.S. Naval Academy  
Location Annapolis Md.  
18. Funeral director John M. Taylor, Son  
Address Annapolis Md.  
19. Oct 22 48  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 20 October 19 48 at 9:15 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 October 19 48 to 20 October 19 48  
and that I last saw him alive on 20 October 19 48  
Immediate cause of death Coronary Thrombosis.

DURATION  
1 hr.

Due to Arteriosclerotic Heart Disease. Unknown.  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE R.H. SHEPARD. LTJG. MC. USNR  
M. D. or other  
Address USNH, Annapolis, Md. Date signed 10-21-48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

OCT 25 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 10107

1. PLACE OF DEATH: Anne Arundel Co.(a) Baltimore City, Maryland(b) Street address Off of Sandy Point

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia County(c) City or town Norfolk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 129 35th St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

FRANKH.GATES, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account  
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or  
divorced.MaleWhiteSingle

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1919

8. AGE: Years Months Days If less than one day

29621hr.min.9. Birthplace Manteo, N.C.

(Town, county, and state)

10. Usual Occupation Seaman for11. Industry or business Eastern Transportation12. Name Co. Norfolk, Va.13. Birthplace North Carolina14. Maiden Name Retta Gray15. Birthplace North Carolina16 (a) Informant Twifford Funeral Home(b) Address Manteo, North Carolina17 (a) Burial (b) Date thereof 10/25/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Location Manteo, North Carolina18 (a) Funeral director H.W. Mears & Son(b) Address 805 North Calvert St.19 (a) Oct 25, 1948  
(Date rec'd by registrar R.W.)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1948, at 2 M21. I certify that I took charge of the remains described above, held an  
Insp. & Inq. thereon and from the evidence obtained  
Autopsy, Inspection or Inquiryby said Autopsy, Inspection or Inquiry, find that said deceased came  
to his death on the day stated above, and death in my  
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,  
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of  
death, fill in the following:(a) Date of injury Oct. 19/48 6:30 P.M.7th Ft. Knoll  
Tag Columbia

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public  
place? Public While at work? Yes(d) Means of injury Drowning23. Signature E. W. Hedrick M.D.

Medical Examiner

Date signed 10/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

10108

28

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs. 5 mos.

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 13 yrs. 5 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty FrederickCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 W. 13th St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

LUCY HALE

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife -----6. (c) If alive, give age ----- years

7. Birth date of

deceased (mo., day, yr.) 1870

8. AGE:

Years

Months

Days

If less than one day

78

hrs.

min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Domestic11. Industry or business ----

MOTHER FATHER

12. Name Elda Jesse Lee13. Birthplace West Virginia14. Maiden name Mary Hall15. Birthplace Warrington County, Va.16. Informant Hospital RecordsAddress Crownsville, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 31, 1948

(month) (day) (year)

Cemetery or crematory Lincoln CemeteryLocation Gettysburg, Pa.18. Funeral director J. M. BenderAddress 128 Carlisle St. Gettysburg, Pa.19. 10/28 48

(Date rec'd by registrar)

E. J. Joyce

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 48 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1 19 41 to October 28 19 48and that I last saw him/her alive on Oct. 28 19 48Immediate cause of death Chronic Myocarditisknown to us since

DURATION

1946Due to -----Due to -----Other conditions Senile Psychosisknown to us since

(Include pregnancy within 3 months of death)

5/1/35Major findings of operations -----Date of op. -----Autopsy results -----

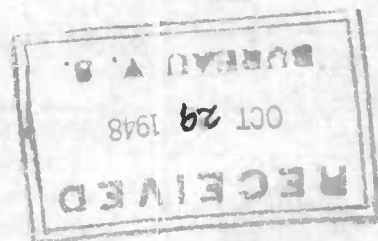
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Jacob M. Murgasch

M. D. or other

Address Crownsville, Md. Date signed 10/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

164c

10109

Reg. Dist. No.

242

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Edgewater  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Edgewater  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Pine Knuff Beach  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

Bertrand J. Harbin

## 3. (b) Social Security Number

none

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Katherine Harbin

## 7. Birth date of deceased (mo., day, year)

March 15, 1874

## 6. (c) If alive, give age

77 years

## 8. AGE:

Years

Months

Days

If less than one day

74

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Engineer (Construction)

MOTHER FATHER

## 12. Name

Harbin

## 13. Birthplace

Maryland

## 14. Maiden name

Mary S. Wedding

## 15. Birthplace

MarylandMrs. Katherine C. Harbin

## Address

Edgewater Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Oct 14, 1948  
(month) (day) (year)

## Cemetery or crematory

Congressional Cemetery

## Location

Washington, D.C.

## 18. Funeral director

J. William Leis Inc.

## Address

305 4th N.E. Washington DC

## 19. Date rec'd by registrar

Oct 15, 1948Carrie Campbell

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

October 14, 1948 at 3:20 P.M.21. I CERTIFY that death occurred on the date above stated: Pat Morten ExaminationOct. 14, 1948

## Immediate cause of death

## DURATION

## Due to

Bullet wound in right temple

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

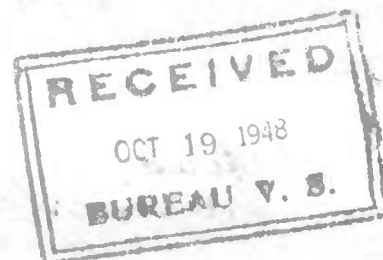
Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-14-48Where did injury occur? Edgewater A. H. Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury 32 cal bullet Injured at work? noSignature John M. Claffy M.D. Deputy medical ExaminerAddress Annapolis, Md. Date signed 10-14-48



Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10110

FILM No. G 117 NOV 1 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne Arundel

City or town... Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 7 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 yrs. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... ---

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 N. Ann St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EMORY HAYES

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

---

7. Birth date of

deceased (mo., day, yr.)

12/10/81

6.(c) If alive, give age. --- years

8. AGE:

Years

Months

Days

If less than one day

66 67

hrs.

min.

9. Birthplace... Greensboro, North Carolina

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

---

12. Name... Leelor Hayes, N. Carolina

13. Birthplace... N. Carolina

14. Maiden name... Mary ?

15. Birthplace... N. Carolina

16. Informant... Hospital Records

Address

Crownsville, Md.

17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof... Oct. 27, 1948  
(month) (day) (year)

Cemetery or crematory... Crownsville

Location... Crownsville, Md.

18. Funeral director

Address

10427-48  
(Date rec'd by registrar)

E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... October 16 1948 at 4:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 9 1946 to October 16 1948

and that I last saw him alive on October 16 1948

Immediate cause of death... Cerebral Arteriosclerosis

known to us since

10/9/46

Due to...

Due to...

Other conditions

Senile Psychosis

Known to us since

(Include pregnancy within 3 months of death)

10/9/46

Major findings of operations

Date of op. ---

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. --- Date of ---

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Crownsville, Md.

M. D. or other

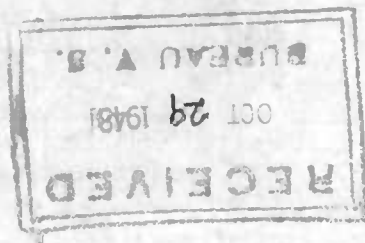
Date signed 10/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 10111

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
 (b) Street address 7th Ft. Knoll - Chesapeake Bay  
 (c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County  
 (c) City or town Baltimore,  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 711 Chestnut Hill Avenue  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country

## 3 (a) FULL NAME

Theodore J. Hewitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex  
Male5. Color or race  
White6 (a) Single, married, widowed, or divorced.  
Divorced6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, 18968. AGE: Years 51 Months 11 Days 21 If less than one day  
24 hr. min.9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation Asst Engineer Tug Boat

11. Industry or business

12. Name William J. Hewitt13. Birthplace Md14. Maiden Name Jennie James15. Birthplace Md16 (a) Informant Mrs. Jennie Hewitt  
 (b) Address 711 Chestnut Hill Avenue17 (a) Burial (b) Date thereof Oct 25 1948  
 (Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Balto National  
 Location Baltimore18 (a) Funeral director Ullrich Funeral Home  
 (b) Address 2008 Orleans St19 OCT 21 1948 (b) For William, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948, at 9:05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒; suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10-19-48 at 6:30 P. M.(b) Where did injury occur? 7th Ft. Knoll  
(Tug Columbia)(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes(d) Means of injury Drowning23. Signature George S. Merrill M.D.Date signed 10/20/48 Medical Examiner

J. Anderson

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10112

## CERTIFICATE OF DEATH

Reg. Diat. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 M<sup>rs</sup> Kendree Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

1st World War I

## 3. (a) FULL NAME

Elmer E. Hobbs

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Betty D. Hobbs

7. Birth date of

deceased (mo., day, yr.)

Nov 26<sup>th</sup> 1891

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

561014

hrs.

min.

9. Birthplace

New Cumberland W. Va.  
(Town, county, and state)

10. Usual occupation

Mech. Engr.

11. Industry or business

U.S. Naval Academy Annapolis

FATHER

12. Name

William G. H. Hobbs

13. Birthplace

West Va.

MOTHER

14. Maiden name

Henrietta L. Stevenson

15. Birthplace

Penn.

16. Informant

Betty D. Hobbs

Address

110 M<sup>rs</sup> Kendree Ave Annapolis Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 12<sup>th</sup> 1948  
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington Va.

18. Funeral director

John M. Taylor, Son

Address

Annapolis Md.

19.

Oct 11 19 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

October 8, 1948 at 11:10 P

21. I CERTIFY that death occurred on the date above stated; that attending deceased from

October 4, 1948 to Oct 8, 1948

and that I last saw him alive on

Immediate cause of death

Coronary Thrombosis

DURATION

24 hrs

Due to

Due to

Other conditions

(None)

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert L. Anderson M.D.

M. D. or other

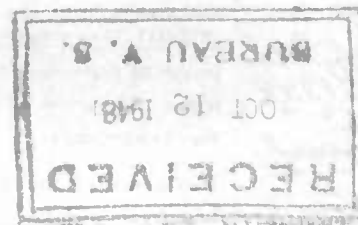
Address

Annapolis, Md.Date signed Oct 9, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH 172

Registered No. 10113

1. PLACE OF DEATH: Found: Chesapeake Bay in the

(a) Baltimore City, Maryland vicinity of 7' Knoll

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3700 Hanover Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

JAMES

E.

HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henrietta Schramm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-1888

8. AGE: Years Months Days If less than one day

60

6

19

17

br.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation

Mate

11. Industry or business

Arundel Corporation

12. Name

George Hoffman

13. Birthplace

Maryland

14. Maiden Name

Georgianna

15. Birthplace

Maryland

16 (a) Informant Family

(b) Address

3700 Hanover Street

17 (a) Burial (b) Date thereof 10-12-48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Glen Burnie, Maryland

18 (a) Funeral director J. L. McCULLY

(b) Address 130 E. Fort Avenue

19 Date rec'd by registrar

10-12-1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 19 48 at 2:30 PM

21. I certify that I took charge of the remains described above, held an Insp. &amp; Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-5-48 at 11:15 A M.

(b) Where did injury occur Chesapeake Bay, 3/4 mile

(c) Did injury occur at home, on farm, industrial place, in public place? Chesapeake Bay While at work? Yes

(d) Means of injury Tugboat Capsized

23. Signature E. L. Royer M.D.

Medical Examiner.

Date signed 10-11-48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10114 26

1. PLACE OF DEATH: Anne Arundel Co.  
 County.....  
 City or town..... Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Years  
 Hospital, institution, or street address where death occurred:  
 80 East Street  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Anne Arundel  
 City or town..... Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 80 East Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
 Charles Henry Holland

3. (b) Social Security Number  
 None

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) July 12, 1907  
 8. AGE: Years 41 Months 3 Days 14 If less than one day  
 hrs. min.

9. Birthplace Churchton, A.A.Co. Md.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Charles W. Holland

13. Birthplace Churchton, A.A.Co. Md.

14. Maiden name Elenora Brown

15. Birthplace Churchton, A.A.Co. Md.

16. Informant Charles W. Holland

Address Churchton A.A.Co. Md.

17. Burial Date thereof 10-28-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Churchton Cemetery

Location Churchton Md.

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. (Date rec'd by registrar) 19 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1948 at 3:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to October 16, 1948 and that I last saw him alive on October 16, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 8 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

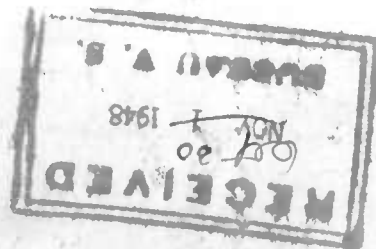
23. SIGNATURE J. P. Richardson M.D.

Address 110 - 2nd St. Annapolis Md. Date signed 10/28/48

110 - 2nd St. Annapolis Md. Date signed 10/28/48

110 - 2nd St. Annapolis Md. Date signed 10/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10115

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Elvaton, (Millersville, R.F.D.)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 32 1/2 yearsHospital, institution, or street address where death occurred:  
Jumper Hole Road

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

male

5. Color of face

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Ada I. Horky

(Nee Duvall)

6. (c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.)

May 1, 1892

8. AGE:

Years

Months

Days

If less than one day

56517

hrs.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Carpenter11. Industry or business Lock Insulator Co.

MOTHER

12. Name

Frank Horky

13. Birthplace

Czechoslovakia

14. Maiden name

Beatrice

15. Birthplace

Czechoslovakia

16. Informant

Mrs. Ada I. Horky

Address

Elvaton, (Millersville, Md. P.O.)

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 20, 1948

(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Glen Burnie, Md.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Elvaton, Millersville Md. RFD  
(If outside city or town limits, write RURAL and give nearest town)Street No. Jumper Hole Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

214 05 2975

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 17 48 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated.

Postmortem ExaminationImmediate cause of deathCoronary Occlusion - SuddenCoronary SclerosisOther conditionsMajor findings of operationsAntopsy resultsPHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Laffey, M.D.Address Elvaton, Md.Date signed 10-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10116

Reg. Dist. No.

28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Owing Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) Is veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

LORENZO HOWARD

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Dorothy Howard  
 7. Birth date of deceased (mo., day, yr.) 1908 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Truck driver  
 11. Industry or business \_\_\_\_\_  
 12. Name Joseph Howard  
 13. Birthplace Maryland  
 14. Maiden name Mata Didds  
 15. Birthplace Maryland

18. Informant Hospital Records  
 Address Crownsville, Md.  
 17. Burial 11/1/48 Date thereof (month) (day) (year)  
 Cemetery or crematory Goughs Church Cemetary  
 Location Cockeysville, Maryland  
 18. Funeral director Landon M. Brooks  
 Address Sparks, Maryland  
 19. 10/30 48 E. J. Joyce Local  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 19 48 at 12:31 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 19 48 to October 29 19 48  
 and that I last saw him alive on October 29 19 48  
 Immediate cause of death General Paresis  
known to us since  
 DURATION 10/19/48  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Jacob M. Hargrave M. D. or other \_\_\_\_\_  
 Address Crownsville, Md. Date signed 10/29/48

RECEIVED  
NOV 1 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10117

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. unknown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ----- ✓

## 3. (a) FULL NAME

ELMER W. JOHNSON

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced unknown  
 6.(b) Name of husband or wife unknown  
 7. Birth date of deceased (mo., day, yr.) (unknown) abt. 1885 6.(c) If alive, give age ----- years  
 8. AGE: Years 63? Months --- Days --- If less than one day hrs. min.

9. Birthplace unknown  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business -----  
 12. Name unknown  
 13. Birthplace unknown  
 14. Maiden name unknown  
 15. Birthplace unknown

16. Informant Hospital Records  
 Address Crownsville State Hospital  
 17. Removal Removal Date thereof 10-12-48  
 (Burial, cremation, or removal Which?) (month) (day) (year)  
 Cemetery or crematory Lincoln Memorial Cem.  
 Location Quintland, Md.  
 18. Funeral director Francis Funeral Home  
 Address 389 W. D. Ave. N.Y. Wash. D.C.  
 19. 10/12/48 E.F. Joyce Local  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 19 48 at 8:25 a M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1948 19 48 to October 11, 1948  
 and that I last saw him alive on October 11, 1948  
 Immediate cause of death Enc ephalomalacia known to us since 10/1/48  
 DURATION  
 Due to -----  
 Due to -----  
 Other conditions -----  
 (Include pregnancy within 3 months of death)  
 Major findings of operations -----  
 Date of op. -----  
 Autopsy results -----  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----  
 Where did injury occur? -----  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) -----  
 Means of injury ----- Injured at work? -----  
 23. SIGNATURE and Murphy M. D. or other -----  
Crownsville, Maryland Date signed 10/11/48

RECEIVED  
OCT 14 1948  
BUREAU A. S.

1948  
63  
1883

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH 172

Registered No. 10118

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
 (b) Street address 15 miles out in cut-off channel  
 (c) Hospital or institution: Chesapeake Bay  
 (d) Length of stay in hospital or inst. (yrs., mos., or days).....  
 (e) Length of stay in Baltimore (yrs., mos., or days).....

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Pa. (b) County.....  
 (c) City or town Philadelphia  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 4240 N. 6th St.  
 (If rural give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country..... ✓

## 3 (a) FULL NAME

JAMES T.

JOHNSON

## 3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex  
male5. Color or race  
white6 (a) Single, married, widowed, or divorced.  
married6 (b) Name of husband or wife Lillian Emily6 (c) If alive, give age 38 years7. Birth date of deceased (mo., day, yr.) 1-14-19008. AGE: Years 48 Months 9 Days 15 If less than one day  
..... hr. .... min.9. Birthplace Kentucky  
(Town, county, and state)10. Usual Occupation Cook on tugboat

11. Industry or business

12. Name Grantville Johnson13. Birthplace Kentucky14. Maiden Name Fannie?15. Birthplace Kentucky16 (a) Informant L. E. Hooper(b) Address 1416 Munsey Bldg.17 (a) Burial (b) Date thereof 11-2-48  
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Greenmount  
Location Phila. Pa. 2nd & Suzanne18 (a) Funeral director John Ulbrich(b) Address 2008 Orleans St.19 (a) NOV 1 1948 (b) Wilmington, Delaware, M.D.  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 2.15 p.m.

21. I certify that I took charge of the remains described above, held an Inquiry &amp; Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....

(Include pregnancy within 6 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury 10-19-48 at between 6.00-6.30 p.m.(b) Where did injury occur? Baltimore Channel Buoy #6  
Chesapeake Bay(c) Did injury occur at home, on farm, industrial place, in public place? Chesapeake Bay While at work? yes(d) Means of injury tugboat collision23. Signature Earl R. Rye M.D.Date signed October 30, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10119

21

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

## 3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 48, at 5:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from

Post-mortem Examination  
and that the cause of death was Oct. 20, 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

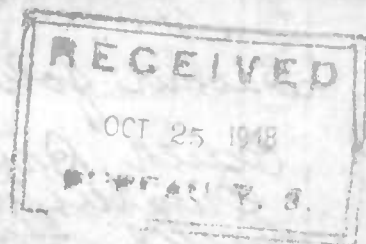
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10120

28

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 yr. 1 mo.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ---

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown  
 (If rural, give LOCATION)

2.(a) If veteran, name war --- ☒

## 3. (a) FULL NAME

JOHN JONES

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Unknown

## 7. Birth date of

deceased (mo., day, yr.)

1875

6. (c) If alive, give age --- years

## 8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

---

## FATHER

## 12. Name

John Jones

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Norma Stocker

## 15. Birthplace

Unknown

## 16. Informant

Hospital Records

## Address

Crownsville, Md.

## 17

(Burial, cremation, or removal. Which?)

## Date thereof

10 7-49  
(month) (day) (year)

## Cemetery or place of

Hospital

## Location

Crownsville Md

## 18. Funeral director

Crownsville

## Address

Crownsville

## 19

(Date read by registrar)

10/7

49

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 19 48 at 3:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 8 19 47 to October 3 19 48

and that I last saw him alive on October 3 19 48

Immediate cause of death General Paresis

known to us since

## DURATION

8/8/47

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

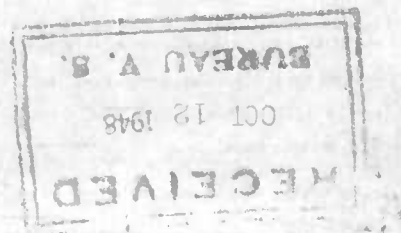
Means of injury --- Injured at work? ---

23. SIGNATURE.....

Crownsville, Md.

M. D. or other

Address..... Date signed 10/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in age shown on:

FILM No. G 117 OCT 21 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10121

Reg. Dist. No. 22

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

County... Anne Arundel County

City or town... Hanover

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? None

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... A.A. County

City or town... Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ridge Road, A.A. County

(If rural, give LOCATION)

2. (a) If veteran, name war None

### 3. (a) FULL NAME

George Kawecki

### 3. (b) Social Security Number

None

4. Sex MALE

~~Female~~

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th, 1948, at 7:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to Dec. 5 1948

and that I last saw him alive on Oct. 5 1948

Immediate cause of death

Cerebral thrombosis

DURATION

4 days

Due to

Due to

Other conditions

Cerebral sclerosis  
(Include pregnancy within 3 months of death)

10 yr.

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. L. Boeck M.D. or other  
Address Luthecum Date signed 10-5-48

6. (b) Name of husband or wife Theresa Dragan

Deceased

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1871

8. AGE:

Years

Months

Days

If less than one day

28 77

?

?

##### min.

9. Birthplace Austria-Hungary

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Lawrence Kawecki

13. Birthplace Austria-Hungary

14. Maiden name Unknown

15. Birthplace Austria-Hungary

16. Informant Mrs. Martha Utz.

Address Ridge Road, Hanover, A.A. Co., Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-9-48

(month) (day) (year)

Cemetery or crematory Sacred Heart of Mary.

Location German Hill Rd. Balto: Co. Md.

George J. Ruth, Inc.

18. Funeral director

Address 1735 Harford Avenue

19. 10/5 48 Dr. W. Hedrick  
(Date rec'd by registrar)

Registrar

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10122

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
201- Tit Ave. S. W.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne Arundel  
City or town Glen Burnie  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 201  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mr. Charles Fred Kriewald

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Marion Reichgraber

7. Birth date of deceased (mo., day, yr.) October 31 - 1874 6.(c) If alive, give age 63 years

8. AGE: Years 73 Months 11 Days 11 It less than one day hrs. min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

12. Name Julius Kriewald

13. Birthplace Germany

14. Maiden name Luise Rebs

15. Birthplace Germany

18. Informant Mrs. C. F. Kriewald (wife)

Address Glen Burnie, Md.

17. Burial Date thereof Oct. 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Quarterfield Cemetery

Location Quarterfield Road

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 10/14 19 48 L. J. O. Alba  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Coronary Occlusion Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter A. Paubert M.D.

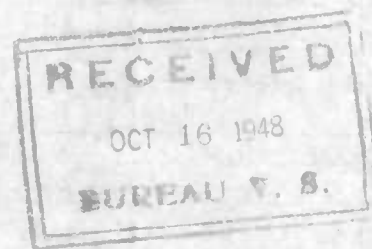
Address Glen Burnie, Md. Date signed 10/13/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 10123

1. PLACE OF DEATH: Found: Chesapeake Bay in  
(a) Baltimore City, Maryland vicinity of 7<sup>th</sup> Knoll  
(b) Street address  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

JOSEPH

3 (b) If veteran, name war

3 (c) Social Security Account  
No.

4. Sex  
Male

5. Color or race  
White

6 (a) Single, married, widowed, or  
divorced. Married

6 (b) Name of husband or wife Jeanne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7, 1921

8. AGE: Years Months Days If less than one day  
27 2 3 hr. min.

9. Birthplace Philadelphia, Pa.

(Town, county, and state)

10. Usual Occupation Superintendent

11. Industry or business Arundel Corporation

12. Name Joseph Kuhn, Sr.

13. Birthplace Baltimore, Maryland

14. Maiden Name Henrietta Snow

15. Birthplace New Jersey

16 (a) Informant Mrs. Jeanne Kuhn

(b) Address 1652 Northwick Court

17 (a) Burial (b) Date thereof 10-12-48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location Baltimore, Maryland

18 (a) Funeral director LEONARD J. RUCK

(b) Address 5305 Harford Road

19 (a) OCT 11 1948 (b) Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1652 Northwick Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

KUHN, JR.

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1948, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an  
Insp & Inquiry thereon and from the evidence obtained  
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came  
to his death on the day stated above, and death in my  
opinion resulted from: natural causes ☐, accident ☒, suicide ☐,  
homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of  
death, fill in the following:

(a) Date of injury 10-5-48 at 11:15 A.M.

(b) Where did injury occur? Chesapeake Bay, 3/4 mile  
below 7<sup>th</sup> Knoll

(c) Did injury occur at home, on farm, industrial place, in public  
place? Chesapeake Bay While at work? Yes

(d) Means of injury tugboat capsized.

23. Signature E. H. Rye M.D.

Date signed 10-11-48

Medical Examiner

Registrar

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10124  
21  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 hrs  
Hospital, institution, or street address where death occurred: Emergency Hosp.  
How long in hospital or institution? 9 hrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County AA  
City or town Severn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. old quarters Rd.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Lamb - Ronald Albert

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Beat

7. Birth date of deceased (mo., day, yr.) 19-48 8. (c) If alive, give age 9-21-48 years

8. AGE: Years 0 Months 0 Days 29 If less than one day hrs. min.

9. Birthplace Severn R.F.D. Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George Bussey  
13. Birthplace Severn R.F.D. Md.  
14. Maiden name Ruby Lamb  
15. Birthplace W. Va

16. Informant Ruth Skaden  
Address Severn R.F.D. Md.

17. Burial Date thereof Oct. 19, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friendship  
Location Camp Meade Road

18. Funeral director Thomas W. Singleton  
Address Glen Burnie Md.

19. Oct. 18, 48 Registrar W. French  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 19 48 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-17 19 48 to 10-18 19 48 and that I last saw him alive on 1 A.M. - 10-18 19 48.

Immediate cause of death dysentery & acidosis  
Due to diarrhea

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE E. Peabody Trent  
M. D. or other  
Address 240 Prince George Date signed 10-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 20 1948

BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10125

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Rural - P.O. #2 Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
6 Bay Head Rd.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town P.O. #2 Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 Bay Head Rd.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

Edward Davenport Legg

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

none

## 6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Mar. 22, 1899

## 8. AGE:

Years

Months

Days

If less than one day

49611

hrs.

min.

## 9. Birthplace

Baltimore, Md.  
(Town, county, and state)

## 10. Usual occupation

grain merchant

## 11. Industry or business

Legg & Co.

## MOTHER

## FATHER

## 12. Name

James Davenport Legg

## 13. Birthplace

Baltimore

## 14. Maiden name

Grace B. Simmonds

## 15. Birthplace

Balto. Md.

## 16. Informant

Mr. Lawrence M. Simmonds

## Address

22 Light St. Balto.

## 17.

burial  
(Burial, cremation, or removal, etc.)

## Date thereof

Oct. 6-48  
(month) (day) (year)

## Cemetery or crematory

London Park

## Location

Baltimore, Md.

## 18. Funeral director

Steward Morris

## Address

108 W. M. Ave.

## 19.

10/5  
(Date rec'd by registrar)x R. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1948 at 4:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

acute dilatation of heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchie, M.D.

Address

Annapolis, Md.Date signed 10/3/48

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

28

10126

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since April 5, 1948

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 months - 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

MARY LONG, Ellen Powell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Unknown

7. Birth date of

deceased (mo., day, yr.) -----

6.(c) If alive, give age. ----- years

1911

8. AGE:

37

Years

Months

Days

If less than one day

hrs. --- min.

9. Birthplace Unknown

(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business -----

MOTHER

12. Name Unknown

13. Birthplace -----

14. Maiden name Unknown

15. Birthplace -----

16. Informant Hospital Records

Address

Crownsville State Hospital

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 10/21/48

(month) (day) (year)

Cemetery or crematory Cemetery in North Carolina

Location North Carolina

18. Funeral director Hicks Funeral Home (Mrs. Chas. E.

Address

Northwest St., Annapolis, Md.

19. Oct. 20,

19 48

(Date rec'd by registrar)

E. J. Joyce Local  
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 19 48 at 5:50 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 5, 19 48 to October 19, 19 48

and that I last saw her alive on October 19, 19 48

Immediate cause of death

Tuberculosis of the Lungs

DURATION

August,  
1948

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. -----

Date of -----

Where did injury occur? -----

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) -----

Injured at work? -----

23. SIGNATURE

M. D. or other

Crownsville, Maryland

Date signed 10/19/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 25 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

10127

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Chesapeake Bay  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 628 E. 35th St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

David Ayon Maines

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife

Rachael Maines

7. Birth date of deceased (mo., day, yr.)

March 28, 1911

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

37

6

25

hrs.

min.

9. Birthplace

Camden N.J.  
(Town, county, and state)

10. Usual occupation

Master of tug Boat

11. Industry or business

Eastern Transportation Co.

MOTHER

FATHER

12. Name

Paul Maines

13. Birthplace

New Jersey

14. Maiden name

Florence Myers

15. Birthplace

New Jersey

16. Informant

Mrs. Rachael Maines

Address

628 E. 35th St. Balto Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 27, 1948  
(month) (day) (year)

Cemetery or crematory

Maryland Memorial Cem.

Location

Baltimore Md

18. Funeral director

Howard M. Blight Jr.

Address

6007 Hurford Rd. Balto Md.

19. Oct 25, 1948

(Date rec'd by registrar)

Wm. French  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 24, 1948, at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

fracture of spinal cord  
fracture of cervical vertebrae

Other conditions

Immersion in water

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/19/48Where did injury occur? Chesapeake Bay, A.A. Md.  
(City or town) (County) (State)Injured at home, farm, industry, pub'c place (where?) Public placeMeans of injury Ship collision Injured at work? Yes

23. SIGNATURE

E. Peyton Ritchings, M.D.  
Attending PhysicianAddress Annapolis, Md.Date signed 10/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 28 1948  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10128

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County ANNE ARUNDELCity or town GLEN BURNIE  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDELCity or town GLEN BURNIE MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 311 THIRD AVE. S.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Henry Irwin Malco

## 3. (b) Social Security Number

NONE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

NELLIE M. MALCO

7. Birth date of

deceased (mo., day, yr.)

NOVEMBER 22, 18896. (c) If alive, give age 52 years

8. AGE:

58117

If less than one day

hrs.

min.

9. Birthplace

STOCKBRIDGE, MICH.

(Town, county, and state)

10. Usual occupation

CONSTRUCTION FOREMAN

11. Industry or business

ANNE ARUNDEL COUNTY SANITARY COMM.

FATHER

12. Name

WILLIAM MALCO

13. Birthplace

GERMANY

MOTHER

14. Maiden name

NELLIE B. BLAIR

15. Birthplace

ENGLAND

16. Informant

MRS. NELLIE MALCO

Address

311 THIRD AVE. S.W., GLEN BURNIE MD

17. BURIAL

(Burial, cremation, or removal, which?)

Date thereof

NOV. 1, 1948

(month) (day) (year)

Cemetery or crematory

BLANFORD

Location

PETERSBURG, VA.

18. Funeral director

James W. Singleton

Address

Glen Burnie, Md.

19.

10/31

19.

48L. D. Albin

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 29, 1948 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated:

Postmortem Examination  
Oct. 29, 1948

Immediate cause of death

DURATION

Bullet wound in  
head

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-29-48Where did injury occur? Glen Burnie B.H. Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? Sanitary CommissionMeans of injury 32 cal. revolver Injured at work? GarageSignature John M. Caffey M.D. Deputy Medical Examiner  
M. D. or other

23. SIGNATURE

Annapolis, Md.Date signed 10-29-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10129

Reg. Dist. No. 23

### 1. PLACE OF DEATH:

County ANNE ARUNDEL  
City or town RIVIERA BEACH  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County ANNE ARUNDEL  
City or town RIVIERA BEACH  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ASBURY & CREEK RDS.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

ANNA DORA MARTIN

### 3. (b) Social Security Number

#### 4. Sex

F

#### 5. Color or race

W

#### 6. (a) Single, married, widowed, or divorced

MARRIED

#### 6. (b) Name of husband or wife

EARL JOSEPH MARTIN

#### 7. Birth date of deceased (mo., day, yr.)

OCTOBER 23, 1887

#### 6. (c) If alive, give age years

#### 8. AGE:

Years

Months

Days

If less than one day

60

hrs.

min.

#### 9. Birthplace

BALTIMORE, MD  
(Town, county, and state)

#### 10. Usual occupation

HOUSEWIFE

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

FRANK SMITH

#### 13. Birthplace

BALTIMORE, MD.

#### 14. Maiden name

ANNIE LANG

#### 15. Birthplace

BALTIMORE, MD

#### 16. Informant

MIR EARL JOSEPH MARTIN

#### Address

ASBURY & CREEK RDS, RIVIERA BEACH

#### 17.

BURIAL  
(Burial, cremation, or removal. Which?)

#### Date thereof

10/7/48  
(month) (day) (year)

#### Cemetery or crematory

MEADOWRIDGE

#### Location

WASHINGTON BLVD

#### 18. Funeral director

JOHN F. DENNY, INC

#### Address

715 LIGHT ST -30

#### 19.

10/7/48  
(Date read by registrar)

48

L Phillips  
Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

Oct. 5-

1948

at 1 A M

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 47 to Oct 5 1948  
and that I last saw her alive on Oct 4- 1948

#### Immediate cause of death

carcinoma oesophagus  
nephritis & myocarditis

#### DURATION

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

#### Accident, suicide, or homicide

#### Date of

#### Where did injury occur?

(City or town)

(County)

(State)

#### Injured at home, farm, industry, public place (where?)

#### Means of injury

#### Injured at work?

#### 23. SIGNATURE

Thos H. Phillips

M. D. or other

Address 3307 Edmondson Date signed Oct. 6-1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Thomas H. Phillips

3307 Edmondson Rd.

W10285

Sunset 23

Wanda Rd.

1 June 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH

County..... Anne Arundel

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:

11 College Ave.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Elizabeth Matthews

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... James Matthews

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.) August 16, 1911

## 8. AGE:

Years

Months

Days

If less than one day

37

3

11

hrs.

m/n.

9. Birthplace..... Annapolis, A. A. Co. Md.

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

None

12. Name..... William Henry Stepney

13. Birthplace..... W. Virginia

14. Maiden name..... Mary M. Brown

15. Birthplace..... Anne Arundel Co. Md.

16. Informant..... William Vaughn Stepney

Address..... 36 Washington Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 10- 31- 1948

(month) (day) (year)

Cemetery or crematory..... Brewer Hill Cemetery

Location..... West Street Extended

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 43-45 Northwest Street

19. Oct 31 1948

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Anne Arundel

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 11 College Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

Oct 27 1948 1030 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 26 1948 to Oct 27 1948

and that I last saw deceased alive on 10-27-48

## Immediate cause of death.....

Dysentery

## Due to.....

Evisceration

## Due to.....

Probably due to gastro enteritis

[12/23/48-49]

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op. ....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

## 23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10130

24

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 108 Mc Kendree Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert Emory Mc Clellan

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Alma L. Mc Clellan

6.(c) Alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

April 13<sup>th</sup> 1894

8. AGE:

Years

Months

Days

If less than one day

74615

..... hrs. .... min.

9. Birthplace

Port Deposit Md.  
(Town, county, and state)

10. Usual occupation

Machinist Md Marine

11. Industry or business

Experimental Station

FATHER

12. Name

John H. Mc Clellan

13. Birthplace

Maryland

MOTHER

14. Maiden name

Laura Farrow

15. Birthplace

Maryland

16. Informant

Michael H. Mc Clellan

Address

108 Mc Kendree Ave Annapolis Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Oct 30<sup>th</sup> 1948

Cemetery or crematory

David Ridge Cemetery

Location

Baltimore Co. Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis Md.19. Oct 30 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1948, at 11:15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1948 to Oct 28 1948and that I last saw him alive on Oct 28 1948

Immediate cause of death

Cardio Vascular Failure

DURATION

Sudden

Due to

Acute Distention of Heart about 10 days

Due to

Arterial Hypertensionseveral yrs.

Other conditions

& Cr. Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Oliver Purvis

M. D. or other

Address

Annapolis MdDate signed 10/29/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *93d*

10131

*14747*

### 1. PLACE OF DEATH:

County *Anne Arundel*  
City or town *Pumphrey*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *6 yrs*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Anne Arundel*  
City or town *Pumphrey*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *214* *Jefferson Ave*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

*Judd Belton McClure*

### 3. (b) Social Security Number

*246-12-3711*

4. Sex *M* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Frances Elizabeth McClure*

6. (c) If alive, give age *20* years

7. Birth date of deceased (mo., day, yr.) *June 6, 1975*

8. AGE: Years *73* Months *4* Days *17* If less than one day hrs. min.

9. Birthplace *Spartanburg S.C.*  
(Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business

12. Name *Joe McClure*

13. Birthplace *Spartanburg Co.*

14. Maiden name *Sadie*

15. Birthplace *Spartanburg Co.*

16. Informant *Joseph McClure*

Address *209 Jefferson Ave*

17. *Burial* (Burial, cremation, or removal) Which? Date thereof *Oct 27-1948*  
(month) (day) (year)

Cemetery or crematory *Mount Calvary Cem*

Location *Baltimore Md*

18. Funeral director *Clayton B. Wilson*

Address *1000 Beardsley Ave*

19. *Oct 27* 19 *48* *A. W. Hedrick*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *October 23* 19 *48* at *1:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 20* 19 *48* to *Oct 22* 19 *48*

and that I last saw him alive on *Oct 22* 19 *48*

Immediate cause of death *Cerebral Hemorrhage* DURATION *?*

Due to *Arterio-sclerosis*

Due to *Hypertensive Cardiac Vasculature*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE *Ronald Bliz*

Address *501 Cherry Hill Rd*

Date signed *10-23-48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10132

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town South River  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town South River  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. River  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

James Herbert Montague

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Ibra Kyle Montague  
6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) April 5<sup>th</sup> 1880

8. AGE: Years 68 Months 6 Days 14 If less than one day ..... hrs. .... min.

9. Birthplace Gooschland Co. Va.  
(Town, county, and state)

10. Usual occupation Prop of Furniture Store

11. Industry or business James Wesley Montague

12. Name John J. Salmon Jr

13. Birthplace Va.

14. Maiden name Gla Fleming

15. Birthplace Va

16. Informant John J. Salmon Jr

Address Annapolis Md

17. Burial Date thereof OCT 21 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Haven Memorial

Location Green Burial & Co. Md.

18. Funeral director John M. Taylor, Son

Address Annapolis Md.

19. Oct 20 1948 Wm J French  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948 at 4:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1948 to Oct 19 1948  
and that I last saw him alive on October 19 1948

Immediate cause of death Coronary Thrombosis DURATION Months

Due to .....

Due to .....

Other conditions Arteriosclerosis - Cardiac - Vascular disease 6 months  
(Include pregnancy within months of death)

Major findings of operations None

Autopsy results..... Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of Injury Injured at work?

23. SIGNATURE Albert P. Anderson M. D. or other  
Address Annapolis, Md. Date signed 10/19/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 21 1948

SUPPLY & S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10133

21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 242 King George St.

(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

## 3. (a) FULL NAME

Charles E. Myers

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Betty S. Myers

## 7. Birth date of

deceased (mo., day, yr.)

Sept 9<sup>th</sup> 1883

## 6.(c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

6517

hrs.

min

## 9. Birthplace.....

Annapolis Maryland  
(Town, county, and state)

## 10. Usual occupation

Vice Pres H.B. Myers Co

## 11. Industry or business

Hardware Store

## MOTHER FATHER

## 12. Name

Henry B. Myers

## 13. Birthplace

A. A. Co. Maryland

## 14. Maiden name

Cliffbeth Menckel

## 15. Birthplace

A. A. Co. Maryland

## 16. Informant

Henry B. Myers

## Address

Annapolis, Maryland

## 17. Burial

(Burial, cremation, or removal, which?)

Date thereof

10-18-48  
(month) (day) (year)

## Cemetery or crematory

Arlington National Cem

## Location

Arlington, Virginia

## 18. Funeral director

John M. Taylor, Son

## Address

Annapolis, Maryland

## 19. Oct 18

19 487<sup>th</sup>

19

7<sup>th</sup>

19

7<sup>th</sup>

19

7<sup>th</sup>

19

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Oct 16

19

48

at

7:20

a

M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jun

19

45

to

Oct 16

19

48

and that I last saw h

5

alive on

Oct 16

19

48

## Immediate cause of death

arteriosclerotic cardio-vascular disease

## DURATION

10 yrs

## Due to

## Due to

## Other conditions

Arteriosclerotic heart disease / infarctmyocardial infarct & angina  
(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

S. B. Borsuch M.D.

M. D. or other

Address

Annapolis MdDate signed 10/18/48

**RECEIVED**  
OCT 20 1948  
**BUREAU U. S.**

**RECEIVED**  
OCT 20 1948  
**BUREAU U. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. A. T. Allen

10134

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Sarah E. Neal

7. Birth date of

deceased (mo., day, yr.)

Oct. 9

6. (c) If alive, give age..... years

1892

8. AGE:

Years

Months

Days

If less than one day

56

1

hrs.

min.

9. Birthplace

A. A.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Richard Neal

13. Birthplace

Md.

MOTHER

14. Maiden name

Josephine Daniels

15. Birthplace

Md.

16. Informant

Address

Sarah E. Neal

Best Gate

17.

(Burial, cremation, or removal, Which?)

Date thereof

Oct. 15 1948

Cemetery or crematory

Cherry Chapel

Location

Greenview Rd

18. Funeral director

Address

J. B. Johnson

Annapolis

19.

Oct. 13 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Oct. 15

1948 at 5:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-16 1947 to 10-10 1948

and that I last saw him alive on 9-28-48

Immediate cause of death

Hypertension

Cardio-vascular disease

with congestive failure

## DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. T. Allen MD

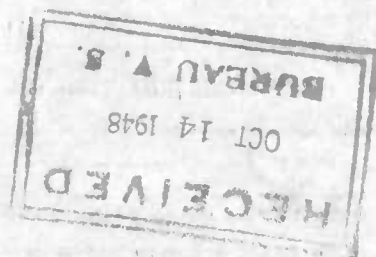
M. D. or other

Address

Carroll

Date signed

10-13-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10135

## CERTIFICATE OF DEATH

Reg. Dist. No. 2/

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Rural - near Riva  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:

Riva Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. U.S. Naval Academy  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Richard Lawrence Neilsen

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan. 27, 1929

8. AGE:

Years

Months

Days

If less than one day

1983

hrs.

min.

9. Birthplace Buffalo, New York  
(Town, county, and state)

10. Usual occupation

USN

11. Industry or business

USN

FATHER

12. Name

William Neilsen

13. Birthplace

unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown16. Informant United States Navy Record

Address

Annapolis, Maryland

17. Removal (Burial, cremation, or removal, Which?)

RemovalDate thereof October 4, 48  
(month) (day) (year)Cemetery or crematory Ithaca, New YorkLocation Ithaca, New York18. Funeral director Ben L. Hopping and Son

Address

170-172 West St. Annapolis, Md.19. Oct. 4 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1948 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Oct. 2, 1948Where did injury occur? Riva Rd. A.A. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury motorcycle accident Injured at work? no

23. SIGNATURE

E. Peyton Ritchie, M.D.

Address

Annapolis, Md.Date signed Oct. 3, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED

OCT 5 1948

BUREAU V. S.

Richardson

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10136

## CERTIFICATE OF DEATH

Reg. Diat. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 58 Pleasant  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mamie Parker

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

William Parker

7. Birth date of deceased (mo., day, yr.)

June 17, 1888

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

60

4

9

hrs.

min.

9. Birthplace

Annapolis, A. G. Co. Md.  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

George Adams

13. Birthplace

Md.

14. Maiden name

Ratie Adams

15. Birthplace

Md.

16. Informant

William Parker

Address

58 Pleasant St. Annapolis Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Oct. 29, 1948  
(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18. Funeral director

J. B. Johnson

Address

Annapolis, Md. P.O. Box 462

19.

(Date rec'd by registrar)

Oct. 29, 1948

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 10, 1948 to Oct 26, 1948  
and that I last saw her alive on Oct 26, 1948

Immediate cause of death

Broncho-Pneumonia

DURATION

6 days

Due to

Infarction

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

H. P. Richardson  
118 - E. 8th St. Annapolis Md

M. D. or other

Date signed

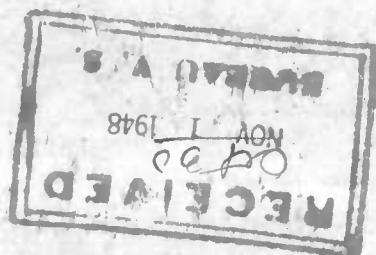
10/27/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

10137

## 1. PLACE OF DEATH:

County... Anne Arundel

City or town... Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:  
Emergency Hospital

How long in hospital or institution? 33 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel

City or town... Rural - Livonia Park  
(If outside city or town limits, write RURAL and give nearest town)Street No... Benfield Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Frances Carol Perkins

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

S

B. (b) Name of husband or wife

Single

7. Birth date of deceased (mo., day, yr.)

June 6<sup>th</sup> 1871

8. AGE:

Years

Months

Days

If less than one day

77

4

5

hrs.

min.

9. Birthplace

Chicago Ill.

(Town, county, and state)

10. Usual occupation

retiree

11. Industry or business

FATHER

12. Name

Thomas C. Perkins

13. Birthplace

England

MOTHER

14. Maiden name

Fannie C. Stokes

15. Birthplace

England

16. Informant

Philip Perby

Address

322 E. 57 St New York City

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

Chicago Ill

18. Funeral director

Address

John M. Taylor, Inc  
Annapolis Md.

19.

(Date rec'd by registrar)

Oct 11 19 48

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Oct. 11 19 48 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 20 19 48 to Oct. 11 19 48

and that I last saw him alive on Oct. 10 19 48

Immediate cause of death

Cardiorespiratory failure

Due to

Carcinoma of caecum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.

M. D. or other

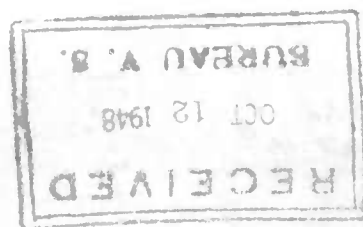
Address... Annapolis, Md. Date signed... Oct. 11, 19 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10138

21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 26 Bedford St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ---

## 3. (a) FULL NAME

MARTIN LUTHER POWELL

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Male</u> <u>Negro</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
6.(b) Name of husband or wife. <u>---</u>		
7. Birth date of deceased (mo., day, yr.) <u>1883</u>		
8. AGE: Years <u>55</u>	Months <u>65</u>	Days <u>years</u>
6.(c) If alive, give age. <u>---</u> years		
9. Birthplace <u>Maryland</u> (Town, county, and state)		
10. Usual occupation <u>Porter</u>		
11. Industry or business <u>---</u>		
12. Name <u>Martin Luther Powell</u>		
13. Birthplace <u>Unknown</u>		
14. Maiden name <u>Christy</u>		
15. Birthplace <u>Unknown</u>		

16. Informant <u>Hospital Records</u>		
Address <u>Crownsville, Maryland</u>		
17. <u>Removal</u>	Date thereof <u>10/28/48</u>	
(Burial, cremation, or removal, Which?)	(month) (day) (year)	
Cemetery or crematory <u>Cumberland</u>	<u>and</u>	
Location <u>Isaac L Brown &amp; Son</u>	<u>108 W Montgomery St</u>	
18. Funeral director <u>Isaac L Brown &amp; Son</u>	Address <u>108 W Montgomery St</u>	
19. <u>10/28</u>	19 <u>48</u>	<u>L. D. Alb</u>
(Date rec'd by registrar)		Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH <u>October 27</u>	19 <u>48</u>	at <u>11:35a</u>
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>October 20</u>		
19 <u>48</u> to <u>October 27</u>		
19 <u>48</u> and that I last saw him alive on <u>October 27</u>		
19 <u>48</u> Immediate cause of death <u>Carcinoma of the Rectum</u>		
known to us since <u>10/20/48</u>		
DURATION		
Due to <u>Psychosis with Exhaustion</u>		
Due to <u>Delirium</u>		
(Include pregnancy within 8 months of death)		
Major findings of operations <u>---</u>		
Date of op. <u>---</u>		
Autopsy results <u>---</u>		
PHYSICIAN: Please underline the cause to which death should be charged statistically.		
22. VIOLENCE: If death was due to external causes, fill in the following:		
Accident, suicide, or homicide <u>---</u> Date of <u>---</u>		
Where did injury occur? <u>---</u>		
(City or town) (County) (State)		
Injured at home, farm, industry, public place (where?) <u>---</u>		
Means of injury <u>---</u> Injured at work? <u>---</u>		
23. SIGNATURE <u>Robert H. D.</u>		
M. D. or other		
Address <u>Crownsville, Md.</u>		
Date signed <u>10/27/48</u>		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 29 1948  
BUREAU V. S.

VS A15 9-45-15M



MARGIN RESERVED FOR BINDING

PROCESSED

RECEIVED OCT 29 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10139

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.  
County.....  
City or town Earleigh Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Years 6 Mos.  
Hospital, institution, or street address where death occurred:  
Earleigh Heights, Md.  
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town Earleigh Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Earleigh Heights near- Annapolis  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

3. (a) FULL NAME Pauline Ruffin

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Garfield Ruffin  
6. (c) If alive, give age 40 years  
Birth date of deceased (mo., day, yr.) July 30, 1893

8. AGE: Years 35 Months 2 Days 5 It less than one day  
hrs. min.

9. Birthplace Unknown  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Garfield Ruffin

Address Earleigh Heights

17. Burial Date thereof 10- 9- 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Earleigh Heights

Location Earleigh Heights, Maryland

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. Oct. 8 19 48 Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 19 48 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-17-48 to 10-5-48 and that I last saw him alive on 9-30-48

Immediate cause of death Earleigh vascular accident

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. T. Allen M. D. or other

Address 10 Carroll Date signed 10-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 11 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

10140

## 1. PLACE OF DEATH

County West AnnapolisCity or town West Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town West Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Bondall  
(If rural, give LOCATION)

2.(a) If veteran, name war

World War I

## 3. (a) FULL NAME

Roland H. Saffield

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Katherine E Saffield

7. Birth date of

deceased (mo., day, yr.)

Oct 4 1891

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5766hrs.min.

9. Birthplace

A. A. Co Md  
(Town, county, and state)

10. Usual occupation

Chauffeur

11. Industry or business

U. S. Navy Academy

12. Name

George Saffield

13. Birthplace

Maryland

14. Maiden name

Unknown

15. Birthplace

16. Informant Mrs Katherine E Saffield

Address

9 Randall St W. Annapolis Md17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Oct 13 48  
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington Va

18. Funeral director

John M. Taylor - Son

Address

Annapolis Md19. Oct 13 19 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

October 10, 19 48 at 2:00 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 4, 19 48 to Oct 10, 19 48and that I last saw him alive on Oct 10, 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Hypertensive Cardio-

Due to

Vascular Disease3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 10-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 14 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carriage is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10141

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Severn  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George Layton Smith

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, or divorced

single

## 6. (b) Name of husband or wife

NONE

## 7. Birth date of deceased (mo., day, yr.)

Apr. 28, 1894

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

54629

hrs.

min.

## 9. Birthplace

Severn, Anne Arundel, Md  
(Town, county, and state)

## 10. Usual occupation

Farming  
Truck

## 11. Industry or business

MOTHER FATHER

## 12. Name

Henry F. Smith

## 13. Birthplace

Edwards, Md

## 14. Maiden name

Evelyn Durrer

## 15. Birthplace

Severn, Md

## 16. Informant

Miss Eva Irene Smith

## Address

Severn, Maryland17. BURIAL

(Burial, cremation, or removal. Which?)

## Date thereof

OCT. 30, 1948  
(month) (day) (year)

## Cemetery or crematory

FRIENDSHIP

## Location

Old Ft. Meade Rd., At New Air Post.

## 18. Funeral director

Thomas W. Aughton

## Address

Glen Burnie, Md.

## 19.

Oct 30, 1948  
(Date rec'd by registrar)

19.

48

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

October 27, 1948, at 7 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination  
and that I last saw him alive on Oct. 27, 1948

## Immediate cause of death

## DURATION

Due to

Due to

Other conditions

Coronary occlusionCoronary sclerosisSuddeninfarction

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 10-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10142  
22

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

Col.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Wm Stovall

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

58

6

16

h.

m.

12. Name

Wm Johnson

13. Birthplace

Unknown

14. Maiden name

? Harding

15. Birthplace

Carroll Co., Md.

16. Informant

Wm Stovall

Address

Annapolis Jct., Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mount Zion

Location

Mt. Airy, Md.

18. Funeral director

The W.C. White Co.

Address

Laurel, Md.

19. Oct 29

19 48

Clara Housh

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

October 25, 1948, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 21, 1948, to Oct. 25, 1948,

and that I last saw her alive on Oct. 24, 1948.

Immediate cause of death.....

Hypertension

Due to.....

Arteriosclerosis

Due to.....

Other conditions.....

Uræmia; due to

High Blood Pressure

(Include pregnancy within 3 months of death) 11/24/48

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

Frank Shipley, M.D.

Address.....

Savage, Md.

Date signed.....

10/28/48.

RECEIVED

NOV 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 24

10143

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town ORCHARD BEACH  
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

GEORGE Leo SULLIVAN, SR SENIOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

MALE

5. Color or race

WHITE

6 (a) Single, married, widowed, or divorced

MARRIED

6 (b) Name of husband or wife

MATTIE L. SULLIVAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

SEPT. 21-1882

8. AGE:

Years

Months

Days

If less than one day

66

-

24

hr.

min.

9. Birthplace

BALTO - MD

(Town, county, and state)

10. Usual Occupation

CARPENTER

11. Industry or business

FATHER

12. Name

JOHN SULLIVAN

13. Birthplace

IRELAND

MOTHER

14. Maiden Name

JOHANNA BURRIS

15. Birthplace

IRELAND

16 (a) Informant

GEO. E. SULLIVAN, JR

(b) Address

ORCHARD BEACH

17 (a)

BURIAL

(b) Date thereof

10/19/48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

NEW CATHEDRAL

Location

18 (a) Funeral director

THOMAS J. KENNY, INC

(b) Address

1600 HOLLINS ST

19 (a)

10/18/48

(b)

S.W. Hedrick

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH OCT-15 1948, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature

John J. Davis

Medical Examiner.

M.D.

Date signed

10/15/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10145

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County... Anne Arundel

City or town... Glen Burnie, S. W.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
106 Crain Highway

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Anne Arundel

City or town... Glen Burnie, S. W.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 Crain Highway  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

MARY ELIZABETH SOMMERVILLE THORNTON

## 3.(b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife James S. Thornton

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1861

8. AGE: Years Months Days If less than one day

87

7

25

hrs.

min.

9. Birthplace Balto., Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James P. Sommerville

13. Birthplace W. Va.

14. Maiden name Emily Ann Pyror

15. Birthplace Balto., Md.

16. Informant Mrs. Ethel T. Morgan

Address 106 Crain Highway, S.W., Glen Burnie

17. Burial Date thereof 11/2/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER &amp; SONS

Address Balto., Md.

19. (Date rec'd by registrar) 11/1 1948

20. (Signature of registrar) J. W. Hedrick

21. (Address of registrar) Glen Burnie, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1948 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth 1948 to Oct 29 1948

and that I last saw him alive on Oct 29 1948

Immediate cause of death Chronic Valvular Disease of the Heart

Due to Cardio-Vascular Disease

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

## DURATION

2 years

2 yrs

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

203

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 23

10148

1. PLACE OF DEATH: *Palapasco*  
 (a) *Baltimore City, Maryland*  
 (b) Street address: *310 Elizabeth ave*  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State *md* (b) County *a. a. c. md*  
 (c) City or town *Palapasco a. a. c. md*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *310 Elizabeth ave*  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country

3 (a) FULL NAME *John Henry Turner*  
 3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex *male* 5. Color or race *col.* 6 (a) Single, married, widowed, or divorced *Widow*

6 (b) Name of husband or wife. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *1873*  
 8. AGE: Years *75* Months Days If less than one day hr. min.

9. Birthplace *Annapolis md*  
 (Town, county, and state)

10. Usual Occupation *Railroad Worker*

11. Industry or business

12. Name *Samuel Turner*

13. Birthplace *Annapolis md*

14. Maiden Name *unknown*

15. Birthplace

16 (a) Informant *Birth, Birth*

(b) Address *310 Elizabeth ave*

17 (a) *Burial* (b) Date thereof *Oct. 18, 48*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *mt Calvary Cem*

Location *Brooklyn md*

18 (a) Funeral director *Chryl O. Wilson*

(b) Address *1000 3rd St*

19 (a) *11/18/48* (b) *Dr. Hedrick*

(Date recd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct 14* 19*48*, at *11* M

21. I certify that death occurred on the date above stated; that I attended deceased from *July* 19*47*, to *Oct 14* 19*48* and that I last saw *him* alive on *Oct 14* 19*48*

Immediate cause of death Duration

Due to *Heart failure*  
*hypertension*  
*cardio-vascular*  
 Due to *disease*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature *Samuel R. B.* M. D.

Address *203 Palapasco* Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

10147

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital  
How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Deale  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Albert Hard

## 3. (b) Social Security Number

?

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Minnie E. Hard

## 7. Birth date of deceased (mo., day, yr.)

Sept. 20, 1890

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

58-11

hrs.

min.

## 9. Birthplace

Pennicook, Md.  
(Town, county, and state)

## 10. Usual occupation

Carpenter

## 11. Industry or business

U.S. Gov't.

## 12. Name

William Ward

## 13. Birthplace

don't know

## 14. Maiden name

Laura Ann Crosby

## 15. Birthplace

don't know

## 16. Informant

Mrs. Estelle Anderson

## Address

Deale, Md.

## 17. Burial

Burial

## Date thereof

Oct 4, 1948  
(month) (day) (year)

## Cemetery or crematory

St. James

## Location

James's Lane, Md. Quaker Bur.

## 18. Funeral director

Ritabis Bros.

## Address

Upper Marlboro, Md.

## 19. Oct. 1

1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1948 at 6:15 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-26-48 to 10-1-48and that I last saw him alive on 10-1-48

## Immediate cause of death

Cerebral Hemorrhage DURATION 4 days

## Due to

Hypertensive  
Cardio-Vascular Disease 5 yrs.

## Dus to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

James R. Martin, M.D.

M. D. or other

Address Annapolis, Md. Date signed 10-1-48



RECEIVED

OCT 4 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Evidence for change of age

shown on:

FILM No. G 117 OCT 18 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10148

28

## 1. PLACE OF DEATH:

County..... Anne Arundel  
 City or town..... Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Months 12 Days  
 Hospital, institution, or street address where death occurred:  
 Crownsville State Hospital  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel  
 City or town..... Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 112 Washington Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Charlotte Wen

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single

## 6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, year) January 5, 1906 6.(c) If alive, give age..... years

8. AGE: 41 Years 10 Months 11 Days If less than one day 65? hrs. min.

9. Birthplace..... Maryland  
 (Town, county, and state)

10. Usual occupation..... Unknown

## 11. Industry or business.....

12. Name Abe Wenn  
 13. Birthplace Georgia  
 14. Maiden name Frances Ann Bluebeard  
 15. Birthplace Unknown

## 16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial Date thereof 10 15 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Brewer Hill  
 Location West St. Annapolis, Md.

18. Funeral director William Reese, Jr.  
 Address 1080 Washington St.

19. Oct 13 19 48 R W. H. Cook Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 19 48 to October 12, 19 48 and that I last saw h. er alive on October 12, 19 48

Immediate cause of death Generalized Arteriosclerosis known to us since

DURATION 4/9/48

Due to.....

Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

10149

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 mos.  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County ---  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Unknown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ---

## 3. (a) FULL NAME

JOHNNY WESTRAY

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife ---  
 7. Birth date of deceased (mo., day, yr.) 1891 ? 6.(c) If alive, give age --- years  
 8. AGE: Years 57? Months --- Days --- If less than one day --- hrs. --- min.

9. Birthplace Unknown  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business ---  
 12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Hospital Records  
 Address Crownsville, Md.  
 17. Burial Date thereof Oct. 6 - 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rocky Mount N.C.  
 Location Chicago, Wilson  
 18. Funeral director 1000 Blantley ave  
 Address 10/1/48 10/1/48 10/1/48

19. (Date) (Signed by) 10/1/48 10/1/48 10/1/48  
 (Date) (Signed by) (Date) (Signed by) (Date) (Signed by)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48, at 6:00a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 48 to October 1 19 48and that I last saw him alive on October 1 19 48Immediate cause of death General Paresis  
Known to us sinceDURATION  
6/25/48Due to ---Due to ---Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---Signature --- M. D. or other ---Address Crownsville, Md. Date signed 10/1/48

1681

65

8761

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10150

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County.....*Anne Arundel*  
 City or town.....*Easton, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*15 years*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....*Md.* County.....*Pr.*  
 City or town.....*Easton, Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*114 Chester Ave.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Carl Ferdinand Wilde*

## 3. (b) Social Security Number

*220 16 5077*

4. Sex.....*Male* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*  
 6. (b) Name of husband or wife.....*Margaret May*  
 7. Birth date of deceased (mo., day, yr.).....*Oct 9, 1885*  
 8. AGE: Years.....*63* Months.....*0* Days.....*13* If less than one day.....*hrs. min.*

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct. 22* 19*48* at.....*5:15 P.M.*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Jun 1948* 19..... to.....*Oct. 22* 19*48*  
 and that I last saw him.....*Oct. 22* 19*48*  
 Immediate cause of death.....*Cerebral Thrombosis*  
 DURATION.....  
 Due to.....*arterio-sclerosis - generalized.*  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

9. Birthplace.....*Shady Side*  
 (City, county, and state)  
 10. Usual occupation.....*Waterman System*  
 11. Industry or business.....  
 FATHER  
 12. Name.....*Carl*  
 13. Birthplace.....*Germantown*  
 MOTHER  
 14. Maiden name.....*Augusta Amelia Hein*  
 15. Birthplace.....*Germantown*

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

16. Informant.....*Margaret M. Wilde*  
 Address.....*114 Chester Ave. Easton, Md.*  
 17. Burial.....*Oct 25 1948*  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory.....*Quaker Run*  
 Location.....*Salisbury, Md.*  
 18. Funeral director.....*B. A. Stachert & Son*  
 Address.....*Salisbury, Md.*  
 19. Date rec'd by registrar.....*Oct 25 48* Registrar.....

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....  
 23. SIGNATURE.....*E. P. Hunt*  
 Address.....*Laurel, Md.* M. D. or other.....  
 Date signed.....*10/22/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

10151

1. PLACE OF DEATH Anna Haskett Co.  
 (a) Baltimore City, Maryland  
 (b) Street address 7th Ft. Knoll, Chesapeake Bay  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Va. (b) County  
 (c) City or town Norfolk,  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 4202 Granby Street  
 (e) Citizen of foreign country? (If rural give location) (Yes or No)  
 If yes, name country ✓

3 (a) FULL NAME Bunion A. WILLIAMSON

3 (b) If veteran, name war No. 3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna May Haskett  
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3, 1887

8. AGE: Years 61 Months 9 Days br. If less than one day min.

9. Birthplace Hyde County, N. C.  
 (Town, county, and state)

10. Usual Occupation Sea Capt.

11. Industry or business Eastern Trans. Company

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Annie H. Williamson

(b) Address 4202 Granby St., Norfolk, Va.

17 (a) Burial (b) Date thereof Oct. 20-48  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Norfolk  
 Location Va.

18 (a) Funeral director John O. Mitchell, Inc.

(b) Address 1900 E. 1st St. P.O. Box 114

Date Rec'd by registrar Oct 20 1948 Registrar A. H. H. H. H. H.

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 19 48 9 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-19-48 at 6:30 P. M.

(b) Where did injury occur? 7th Ft. Knoll, Chesapeake Bay

(c) Did injury occur at home, on farm, industrial place, or in public place? Public While at work? yes

(d) Means of injury Drowning

Signature George C. Merrill M.D.

Date signed 10/20/48 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Heale, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Q-Q  
 City or town Heale, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7th Ave Bay  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War I

## 3. (a) FULL NAME

Elmer Oscar Windsor

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary Mansfield Windsor6.(c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) Feb 12, 1897

8. AGE: Years 51 Months 8 Days 1 If less than one day  
 hrs. min.

9. Birthplace Heale, Q-Q Co, Md  
(Town, county, and state)10. Usual occupation waterman

11. Industry or business

12. Name John Windsor13. Birthplace Eastern Shore, Md14. Maiden name Bertie Marshall15. Birthplace Unk16. Informant Mrs Mary WindsorAddress Heale, Md17. Burial, cremation, or removal. Which? Burial Date thereof Oct 17-1948  
(month) (day) (year)Cemetery or crematory Woodfield BuryLocation Saleville Md18. Funeral director J. G. Hardisty & SonAddress Saleville Md19. Oct 16 19 48 J. B. Dent  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Oct 19 48 at 1:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 Oct 19 48 to 14 Oct 19 48and that I last saw him alive on 14 Oct 48 19 48Immediate cause of death Refract. Failure & edemaDue to Hypertensive C.V.R. DiseaseOther conditions Bulat Bronchopneumonia

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Dent M. D. UnkAddress Upper Marlboro Md Date signed 12/10/48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

~~John Doe~~ 12 00  
~~John Doe~~ 12 00  
~~John Doe~~ 12 00

RECEIVED  
OCT 19 1948  
BUREAU V. S.